



General Assembly

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Amendment

LCO No. 7576

HB0630807576HD0

Offered by:

REP. MEGNA, 97th Dist.

SEN. CRISCO, 17th Dist.

REP. RITTER E., 38th Dist.

SEN. GERRATANA, 6th Dist.

REP. JOHNSON, 49th Dist.

To: Subst. House Bill No. 6308

File No. 483

Cal. No. 282

"AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. (NEW) (*Effective July 1, 2011*) As used in this section and
4 sections 2 to 8, inclusive, of this act:

5 (1) "Health Care Cost Containment Committee" means the
6 committee established in accordance with the ratified agreement
7 between the state and the State Employees Bargaining Agent Coalition
8 pursuant to subsection (f) of section 5-278 of the general statutes.

9 (2) "Nonprofit employee" means any employee of a nonprofit
10 employer.

11 (3) "Nonprofit employer" means (A) a nonprofit corporation,
12 organized under 26 USC 501, as amended from time to time, that (i)
13 has a purchase of service contract, as defined in section 4-70b of the
14 general statutes, or (ii) receives fifty per cent or more of its gross
15 annual revenue from grants or funding from the state, the federal
16 government or a municipality or any combination thereof, or (B) an
17 organization that is tax exempt pursuant to 26 USC 501(c)(5), as
18 amended from time to time.

19 (4) "Nonstate public employee" means any employee or elected
20 officer of a nonstate public employer.

21 (5) "Nonstate public employer" means a municipality or other
22 political subdivision of the state, including a board of education, quasi-
23 public agency or public library. A municipality and a board of
24 education may be considered separate employers.

25 (6) "Partnership plan" means a health care benefit plan offered by
26 the Comptroller to nonstate public employers or nonprofit employers
27 under section 2 of this act.

28 (7) "State employee plan" means a self-insured group health care
29 benefits plan established under subsection (m) of section 5-259 of the
30 general statutes.

31 Sec. 2. (NEW) (*Effective July 1, 2011*) (a) (1) Notwithstanding the
32 provisions of title 38a of the general statutes, the Comptroller shall
33 offer to nonstate public employers and nonprofit employers, and their
34 respective retirees, if applicable, coverage under a partnership plan or
35 plans. Such plan or plans may be offered on a fully-insured or risk-
36 pooled basis at the discretion of the Comptroller. Any health insurer,
37 health care center or other entity that contracts with the Comptroller
38 for the purposes of this section and any fully-insured plan offered by
39 the Comptroller under such contract shall be subject to title 38a of the
40 general statutes. Eligible employers shall submit an application to the
41 Comptroller for coverage under any such plan or plans.

42 (2) Beginning January 1, 2012, the Comptroller shall offer coverage
43 under such plan or plans to nonstate public employers. Beginning
44 January 1, 2013, the Comptroller shall offer coverage under such plan
45 or plans to nonprofit employers.

46 (b) (1) The Comptroller shall require nonstate public employers and
47 nonprofit employers that elect to obtain coverage under a partnership
48 plan to participate in such plan for not less than two-year intervals. An
49 employer may apply for renewal prior to the expiration of each
50 interval.

51 (2) The Comptroller shall develop procedures by which:

52 (A) Such employers may apply to obtain coverage under a
53 partnership plan, including procedures for nonstate public employers
54 that are currently fully insured and procedures for nonstate public
55 employers that are currently self-insured;

56 (B) Employers receiving coverage for their employees pursuant to a
57 partnership plan may (i) apply for renewal, or (ii) withdraw from such
58 coverage, including, but not limited to, the terms and conditions under
59 which such employers may withdraw prior to the expiration of the
60 interval and the procedure by which any premium payments such
61 employers may be entitled to or premium equivalent payments made
62 in excess of incurred claims shall be refunded to such employer. Any
63 such procedures shall provide that nonstate public employees covered
64 by collective bargaining shall withdraw from such coverage in
65 accordance with chapters 113 and 166 of the general statutes; and

66 (C) The Comptroller may collect payments and fees for unreported
67 claims and expenses.

68 (c) (1) The initial open enrollment for nonstate public employers
69 shall be for coverage beginning July 1, 2012. Thereafter, open
70 enrollment for nonstate public employers shall be for coverage periods
71 beginning July first.

72 (2) The initial open enrollment for nonprofit employers shall be for
73 coverage beginning January 1, 2013. Thereafter, open enrollment for
74 nonprofit employers shall be for coverage periods beginning January
75 first and July first.

76 (d) Nothing in this section or sections 3 and 4 of this act shall require
77 the Comptroller to offer coverage to every employer seeking coverage
78 under sections 3 and 4 of this act from every partnership plan offered
79 by the Comptroller.

80 (e) The Comptroller shall create applications for coverage for the
81 purposes of sections 3 and 4 of this act and for renewal of a
82 partnership plan. Such applications shall require an employer to
83 disclose whether the employer will offer any other health care benefits
84 plan to the employees who are offered a partnership plan.

85 (f) No employee shall be enrolled in a partnership plan if such
86 employee is covered through such employee's employer by health
87 insurance plans or insurance arrangements issued to or in accordance
88 with a trust established pursuant to collective bargaining subject to the
89 federal Labor Management Relations Act.

90 (g) (1) The Comptroller shall take such actions as are necessary to
91 ensure that granting coverage to an employer under sections 3 and 4 of
92 this act will not affect the status of the state employee plan as a
93 governmental plan under the Employee Retirement Income Security
94 Act of 1974, as amended from time to time. Such actions may include,
95 but are not limited to, cancelling coverage, with notice, to such
96 employer and discontinuing the acceptance of applications for
97 coverage from nonprofit employers. The Comptroller shall establish
98 the form and time frame for the notice of cancellation to be provided to
99 such employer.

100 (2) The Comptroller shall resume providing coverage for, or
101 accepting applications for coverage from, nonprofit employers if the
102 Comptroller determines that granting coverage to such employers will
103 not affect the state employee plan's status as a governmental plan

104 under the Employee Retirement Income Security Act of 1974, as
105 amended from time to time.

106 (3) The Comptroller shall make a public announcement of the
107 Comptroller's decision to discontinue or resume coverage or the
108 acceptance of applications for coverage under a partnership plan or
109 plans.

110 (h) The Comptroller, in consultation with the Health Care Cost
111 Containment Committee, shall:

112 (1) Develop and implement patient-centered medical homes for the
113 state employee plan and partnership plans offered under this section,
114 in a manner that will reduce the costs of such plans; and

115 (2) Review claims data of the state employee plan and partnership
116 plans offered under this section, to target high-cost health care
117 providers and medical conditions and monitor costly trends.

118 Sec. 3. (NEW) (*Effective July 1, 2011*) (a) Nonstate public employers
119 and nonprofit employers may apply for coverage under a partnership
120 plan in accordance with this section.

121 (1) Notwithstanding any provision of the general statutes, initial
122 and continuing participation in a partnership plan by a nonstate public
123 employer shall be a permissive subject of collective bargaining and
124 shall be subject to binding interest arbitration only if the collective
125 bargaining agent and the employer mutually agree to bargain over
126 such participation.

127 (2) If a nonstate public employer or a nonprofit employer submits
128 an application for coverage for all of its respective employees, the
129 Comptroller shall accept such application upon the terms and
130 conditions applicable to the partnership plan, for the next open
131 enrollment. The Comptroller shall provide written notification to such
132 employer of such acceptance and the date on which such coverage
133 shall begin, pending acceptance by such employer of the terms and

134 conditions of such plan.

135 (3) (A) Except as specified in subparagraph (D) of this subdivision, if
136 a nonstate public employer or a nonprofit employer submits an
137 application for coverage for less than all of its respective employees, or
138 indicates in the application the employer will offer other health plans
139 to employees who are offered a partnership plan, the Comptroller shall
140 forward such application to a health care actuary not later than five
141 business days after receiving such application. Not later than sixty
142 days after receiving such application, such actuary shall notify the
143 Comptroller whether, as a result of the employees included in such
144 application or other factors, the application will shift a significant part
145 of such employer's employees' medical risks to the partnership plan.
146 Such actuary shall provide, in writing, to the Comptroller the specific
147 reasons for such actuary's finding, including a summary of all
148 information relied upon in making such a finding.

149 (B) If the Comptroller determines that, based on such finding, the
150 application will shift a significant part of such employer's employees'
151 medical risks to the partnership plan, the Comptroller shall not
152 provide coverage to such employer and shall provide written
153 notification and the specific reasons for such denial to such employer
154 and the Health Care Cost Containment Committee.

155 (C) If the Comptroller determines that, based on such finding, the
156 application will not shift a significant part of such employer's
157 employees' medical risks to the partnership plan, the Comptroller shall
158 accept such application for the next open enrollment. The Comptroller
159 shall provide written notification to such employer of such acceptance
160 and the date on which such coverage shall begin, pending acceptance
161 by such employer of the terms and conditions of such plan.

162 (D) If an employer included less than all of its employees in its
163 application for coverage because of (i) the decision by individual
164 employees to decline coverage from their employer for themselves or
165 their dependents, or (ii) the employer's decision not to offer coverage

166 to temporary, part-time or durational employees, the Comptroller shall
167 not forward such employer's application to a health care actuary.

168 (b) The Comptroller shall consult with a health care actuary who
169 shall develop:

170 (1) Actuarial standards to assess the shift in medical risks of an
171 employer's employees to a partnership plan. The Comptroller shall
172 present such standards to the Health Care Cost Containment
173 Committee for its review, evaluation and approval prior to the use of
174 such standards; and

175 (2) Actuarial standards to determine the administrative fees and
176 fluctuating reserves fees set forth in section 5 of this act and the
177 amount of premiums or premium equivalent payments to cover
178 anticipated claims and claim reserves. The Comptroller shall present
179 such standards to the Health Care Cost Containment Committee for its
180 review, evaluation and approval prior to the use of such standards.

181 (c) The Comptroller may adopt regulations, in accordance with
182 chapter 54 of the general statutes, to establish the procedures and
183 criteria for any reviews or evaluations performed by the Health Care
184 Cost Containment Committee pursuant to subsection (b) of this section
185 or subsection (c) of section 4 of this act.

186 Sec. 4. (NEW) (*Effective July 1, 2011*) (a) Employers whose
187 applications for coverage for their employees under a partnership
188 plan, pursuant to section 3 of this act, have been accepted may seek
189 such coverage for their retirees in accordance with this section.
190 Premium payments for such coverage shall be remitted by the
191 employer to the Comptroller in accordance with section 5 of this act.

192 (b) (1) If an employer seeks coverage for all of such employer's
193 retirees in accordance with this section and all of such employer's
194 employees in accordance with section 3 of this act, the Comptroller
195 shall accept such application upon the terms and conditions applicable
196 to the partnership plan, for the next open enrollment. The Comptroller

197 shall provide written notification to such employer of such acceptance
198 and the date on which such coverage shall begin, pending acceptance
199 by such employer of the terms and conditions of such plan.

200 (2) Except as specified in subdivision (5) of this subsection, if a
201 nonstate public employer or a nonprofit employer seeks coverage for
202 less than all of its respective retirees, regardless of whether the
203 employer is seeking coverage for all of such employer's active
204 employees, the Comptroller shall forward such application to a health
205 care actuary not later than five business days after receiving such
206 application. Not later than sixty days after receiving such application,
207 such actuary shall notify the Comptroller whether, as a result of the
208 retirees included in such application or other factors, the application
209 will shift a significant part of such employer's retirees' medical risks to
210 the partnership plan. Such actuary shall provide, in writing, to the
211 Comptroller the specific reasons for such actuary's finding, including a
212 summary of all information relied upon in making such a finding.

213 (3) If the Comptroller determines that, based on such finding, the
214 application will shift a significant part of such employer's retirees'
215 medical risks to the partnership plan, the Comptroller shall not
216 provide coverage to such employer and shall provide written
217 notification and the specific reasons for such denial to such employer
218 and the Health Care Cost Containment Committee.

219 (4) If the Comptroller determines that, based on such finding, the
220 application will not shift a significant part of such employer's retirees'
221 medical risks to the partnership plan, the Comptroller shall accept
222 such application for the next open enrollment. The Comptroller shall
223 provide written notification to such employer of such acceptance and
224 the date on which such coverage shall begin, pending acceptance by
225 such employer of the terms and conditions of such plan.

226 (5) If an employer included less than all of its retirees in its
227 application for coverage because of (A) the decision by individual
228 retirees to decline health benefits or health insurance coverage from

229 their employer for themselves or their dependents, or (B) the retiree's
230 enrollment in Medicare, the Comptroller shall not forward such
231 employer's application to a health care actuary.

232 (c) The Comptroller shall consult with a health care actuary who
233 shall develop actuarial standards to be used to assess the shift in
234 medical risks of an employer's retirees to a partnership plan. The
235 Comptroller shall present such standards to the Health Care Cost
236 Containment Committee for its review, evaluation and approval prior
237 to the use of such standards.

238 (d) Nothing in sections 1 to 6, inclusive, of this act shall diminish
239 any right to retiree health insurance pursuant to a collective bargaining
240 agreement or any other provision of the general statutes.

241 Sec. 5. (NEW) (*Effective July 1, 2011*) (a) There is established an
242 account to be known as the "partnership plan premium account",
243 which shall be a separate, nonlapsing account within the General
244 Fund. All premiums paid by employers and their respective
245 employees and retirees for coverage under a partnership plan
246 pursuant to sections 2 to 4, inclusive, of this act shall be deposited into
247 said account. The account shall be administered by the Comptroller for
248 payment of claims and administrative fees to entities providing
249 coverage or services under partnership plans.

250 (b) The Comptroller may charge each employer participating in a
251 partnership plan an administrative fee calculated on a per member per
252 month basis, in accordance with the actuarial standards developed
253 under subsection (b) of section 3 of this act and subsection (c) of section
254 4 of this act. In addition, the Comptroller may charge a fluctuating
255 reserves fee the Comptroller deems necessary and in accordance with
256 the actuarial standards developed under subsection (b) of section 3 of
257 this act and subsection (c) of section 4 of this act to ensure adequate
258 claims reserves.

259 (c) Each employer shall pay monthly the amount determined by the
260 Comptroller, pursuant to this section, for coverage of its employees or

261 its employees and retirees, as appropriate, under a partnership plan.
262 An employer may require each covered employee to contribute a
263 portion of the cost of such employee's coverage under the plan, subject
264 to any collective bargaining obligation applicable to such employer.

265 (d) If any payment due by an employer under this section is not
266 submitted to the Comptroller by the tenth day after the date such
267 payment is due, interest to be paid by such employer shall be added,
268 retroactive to the date such payment was due, at the prevailing rate of
269 interest as determined by the Comptroller.

270 (1) The Comptroller may terminate participation in the partnership
271 plan by a nonprofit employer on the basis of nonpayment of premium
272 or premium equivalent, provided at least ten days' advance notice is
273 given to such employer, which may continue the coverage and avoid
274 the effect of the termination by remitting payment in full at any time
275 prior to the effective date of termination.

276 (2) (A) If a nonstate public employer fails to make premium
277 payments or premium equivalent payments as required by this
278 section, the Comptroller may direct the State Treasurer, or any other
279 officer of the state who is the custodian of any moneys made available
280 by grant, allocation or appropriation payable to such nonstate public
281 employer, to withhold the payment of such moneys until the amount
282 of the premium or premium equivalent or interest due has been paid
283 to the Comptroller, or until the State Treasurer or such custodial officer
284 determines that arrangements have been made, to the satisfaction of
285 the State Treasurer, for the payment of such premium or premium
286 equivalent and interest. Such moneys shall not be withheld if such
287 withholding will adversely affect the receipt of any federal grant or aid
288 in connection with such moneys.

289 (B) If no grant, allocation or appropriation is payable to such
290 nonstate public employer or is not withheld, pursuant to
291 subparagraph (A) of this subdivision, the Comptroller may terminate
292 participation in a partnership plan by a nonstate public employer on

293 the basis of nonpayment of premium or premium equivalent, provided
294 at least ten days' advance notice is given to such employer, which may
295 continue the coverage and avoid the effect of the termination by
296 remitting payment in full at any time prior to the effective date of
297 termination.

298 (3) The Comptroller may request the Attorney General to bring an
299 action in the superior court for the judicial district of Hartford to
300 recover any premium or premium equivalent, interest costs, paid claim
301 expenses or equitable relief from a terminated employer.

302 Sec. 6. (NEW) (*Effective July 1, 2011*) (a) There is established a
303 Nonstate Public Health Care Advisory Committee. The committee
304 shall make advisory recommendations to the Health Care Cost
305 Containment Committee concerning health care coverage for nonstate
306 public employees. The advisory committee shall consist of nonstate
307 public employers and employees participating in a partnership plan
308 and shall include the following members appointed by the
309 Comptroller: (1) Three municipal employer representatives, one of
310 whom represents towns with populations of one hundred thousand or
311 more, one of whom represents towns with populations of at least
312 twenty thousand but under one hundred thousand, and one of whom
313 represents towns with populations under twenty thousand; (2) three
314 municipal employee representatives, one of whom represents
315 employees in towns with populations of one hundred thousand or
316 more, one of whom represents employees in towns with populations
317 of at least twenty thousand but under one hundred thousand, and one
318 of whom represents employees in towns with populations under
319 twenty thousand; (3) three board of education employers, one of
320 whom represents towns with populations of one hundred thousand or
321 more, one of whom represents towns with populations of at least
322 twenty thousand but under one hundred thousand, and one of whom
323 represents towns with populations under twenty thousand; and (4)
324 three board of education employee representatives, one of whom
325 represents towns with populations of one hundred thousand or more,
326 one of whom represents towns with populations of at least twenty

327 thousand but under one hundred thousand, and one of whom
328 represents towns with populations under twenty thousand.

329 (b) There is established a Nonprofit Health Care Advisory
330 Committee. The committee shall make advisory recommendations to
331 the Health Care Cost Containment Committee concerning health care
332 coverage for nonprofit employees. The advisory committee shall
333 consist of nonprofit employers and their respective employees
334 participating in a partnership plan and shall include the following
335 members appointed by the Comptroller: (1) Three nonprofit employer
336 representatives; and (2) three nonprofit employee representatives.

337 Sec. 7. (NEW) (*Effective July 1, 2011*) The Comptroller may adopt
338 regulations, in accordance with chapter 54 of the general statutes, to
339 implement and administer partnership plans and the provisions of
340 sections 1 to 6, inclusive, of this act. The Comptroller may implement
341 policies and procedures necessary to administer the provisions of
342 sections 1 to 6, inclusive, of this act while in the process of adopting
343 such policies and procedures as regulation, provided the Comptroller
344 prints notice of intent to adopt regulations in the Connecticut Law
345 Journal not later than twenty days after the date of implementation.
346 Policies and procedures implemented pursuant to this section shall be
347 valid until the time final regulations are adopted.

348 Sec. 8. (NEW) (*Effective from passage*) (a) The Comptroller shall not
349 offer coverage under a partnership plan pursuant to sections 2 to 5,
350 inclusive, of this act until the Health Care Cost Containment
351 Committee has provided, in writing, its approval of sections 1 to 6,
352 inclusive, of this act to the Comptroller and until the State Employees
353 Bargaining Agent Coalition has provided its written consent to the
354 clerks of both houses of the General Assembly to incorporate the terms
355 of sections 1 to 6, inclusive, of this act into its collective bargaining
356 agreement.

357 (b) Nothing in this section or sections 1 to 7, inclusive, of this act
358 shall modify the state employee plan in any way without the written

359 consent of the State Employee Bargaining Agent Coalition and the
360 Secretary of the Office of Policy and Management.

361 Sec. 9. (NEW) (*Effective July 1, 2011*) (a) For the purposes of this
362 section, "employer" has the same meaning as provided in section 38a-
363 513f of the general statutes, as amended by this act.

364 (b) Not later than October first, annually, each employer that
365 sponsors a fully-insured group health insurance policy for its active
366 employees, early retirees and retirees that provides coverage of the
367 type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section
368 38a-469 of the general statutes shall submit electronically to the
369 Comptroller, in a form prescribed by the Comptroller, the following
370 information: For the two policy years immediately preceding, the
371 percentage increase or decrease in the policy or plan costs, calculated
372 as the total premium costs, inclusive of any premiums or contributions
373 paid by active employees, early retirees and retirees, divided by the
374 total number of active employees, early retirees and retirees covered
375 by such policy.

376 Sec. 10. Section 38a-513f of the general statutes is repealed and the
377 following is substituted in lieu thereof (*Effective July 1, 2011*):

378 (a) As used in this section:

379 (1) "Claims paid" means the amounts paid for the covered
380 employees of an employer by an insurer, health care center, hospital
381 service corporation, medical service corporation or other entity as
382 specified in subsection (b) of this section for medical services and
383 supplies and for prescriptions filled, but does not include expenses for
384 stop-loss coverage, reinsurance, enrollee educational programs or
385 other cost containment programs or features, administrative costs or
386 profit.

387 (2) "Employer" means any town, city, borough, school district,
388 taxing district or fire district employing more than fifty employees.

389 (3) "Utilization data" means (A) the aggregate number of procedures
390 or services performed for the covered employees of the employer, by
391 practice type and by service category, or (B) the aggregate number of
392 prescriptions filled for the covered employees of the employer, by
393 prescription drug name.

394 (b) Each insurer, health care center, hospital service corporation,
395 medical service corporation or other entity delivering, issuing for
396 delivery, renewing, amending or continuing in this state any group
397 health insurance policy providing coverage of the type specified in
398 subdivisions (1), (2), (4), (11), [and] (12) and (16) of section 38a-469
399 shall:

400 (1) [Disclose] Not later than October first, annually, provide to an
401 employer sponsoring such policy, [upon request by such employer]
402 free of charge, the following information for the most recent thirty-six-
403 month period or for the entire period of coverage, whichever is
404 shorter, ending not more than sixty days prior to the date of the
405 request, in a format as set forth in subdivision (3) of this subsection:

406 (A) Complete and accurate medical, dental and pharmaceutical
407 utilization data, as applicable;

408 (B) Claims paid by year, aggregated by practice type and by service
409 category, each reported separately for in-network and out-of-network
410 providers, and the total number of claims paid;

411 (C) Premiums paid by such employer by month; and

412 (D) The number of insureds by coverage tier, including, but not
413 limited to, single, two-person and family including dependents, by
414 month;

415 (2) Include in such requested information specified in subdivision
416 (1) of this subsection only health information that has had identifiers
417 removed, as set forth in 45 CFR 164.514, is not individually
418 identifiable, as defined in 45 CFR 160.103, and is permitted to be

419 disclosed under the Health Insurance Portability and Accountability
420 Act of 1996, P.L. 104-191, as amended from time to time, or regulations
421 adopted thereunder; and

422 (3) [Disclose] Provide such requested information (A) in a written
423 report, (B) through an electronic file transmitted by secure electronic
424 mail or a file transfer protocol site, or (C) through a secure web site or
425 web site portal that is accessible by such employer.

426 (c) Such insurer, health care center, hospital service corporation,
427 medical service corporation or other entity shall not be required to
428 provide such information to the employer more than once in any
429 twelve-month period.

430 (d) [Information disclosed] (1) Except as provided in subdivision (2)
431 of this subsection, information provided to an employer pursuant to
432 subsection (b) of this section shall be used by such employer only for
433 the purposes of obtaining competitive quotes for group health
434 insurance or to promote wellness initiatives for the employees of such
435 employer.

436 (2) Any employer may provide to the Comptroller upon request the
437 information disclosed to such employer pursuant to subsection (b) of
438 this section. The Comptroller shall maintain as confidential any such
439 information.

440 (e) Any information [disclosed] provided to an employer in
441 accordance with subsection (b) of this section or to the Comptroller in
442 accordance with subdivision (2) of subsection (d) of this section shall
443 not be subject to disclosure under section 1-210. An employee
444 organization, as defined in section 7-467, that is the exclusive
445 bargaining representative of the employees of such employer shall be
446 entitled to receive claim information from such employer in order to
447 fulfill its duties to bargain collectively pursuant to section 7-469.

448 (f) If a subpoena or other similar demand related to information
449 [disclosed] provided pursuant to subsection (b) of this section is issued

450 in connection with a judicial proceeding to an employer that receives
451 such information, such employer shall immediately notify the insurer,
452 health care center, hospital service corporation, medical service
453 corporation or other entity that [disclosed] provided such information
454 to such employer of such subpoena or demand. Such insurer, health
455 care center, hospital service corporation, medical service corporation
456 or other entity shall have standing to file an application or motion with
457 the court of competent jurisdiction to quash or modify such subpoena.
458 Upon the filing of such application or motion by such insurer, health
459 care center, hospital service corporation, medical service corporation
460 or other entity, the subpoena or similar demand shall be stayed
461 without penalty to the parties, pending a hearing on such application
462 or motion and until the court enters an order sustaining, quashing or
463 modifying such subpoena or demand.

464 Sec. 11. (NEW) (*Effective from passage*) The Office of Health Reform
465 and Innovation established under subsection (b) of section 13 of this
466 act shall convene a working group to develop a plan to implement a
467 state-wide multipayer data initiative to enhance the state's use of
468 health care data from multiple sources to increase efficiency, enhance
469 outcomes and improve the understanding of health care expenditures
470 in the public and private sectors. Such group shall include, but not be
471 limited to, the Secretary of the Office of Policy and Management, the
472 Comptroller, the Commissioners of Public Health and Social Services,
473 the Insurance Commissioner, representatives of health insurance
474 companies, health insurance purchasers, hospitals, consumer
475 advocates and health care providers.

476 Sec. 12. Section 19a-654 of the general statutes is repealed and the
477 following is substituted in lieu thereof (*Effective July 1, 2011*):

478 (a) As used in this section:

479 (1) "Patient-identifiable data" means any information that identifies
480 or may reasonably be used as a basis to identify an individual patient;
481 and

482 (2) "De-identified patient data" means any information that meets
483 the requirements for de-identification of protected health information
484 as set forth in 45 CFR 164.514.

485 (b) [The Office of Health Care Access division of the Department of
486 Public Health shall require] Each short-term acute care general or
487 children's [hospitals to submit such data, including discharge data, as
488 it deems necessary] hospital shall submit patient identifiable inpatient
489 discharge data and emergency department data to the Office of Health
490 Care Access division of the Department of Public Health to fulfill the
491 responsibilities of the office. Such data shall include data taken from
492 patient medical record abstracts and [hospital] bills. The office shall
493 specify the timing and format of such [submission shall be specified by
494 the office. The data may be submitted through a contractual
495 arrangement with an intermediary. If the data is submitted]
496 submissions including submissions by outpatient surgical facilities as
497 provided for in subsection (c) of this section. If a hospital or outpatient
498 surgical facility submits data through an intermediary, the hospital or
499 the outpatient surgical facility shall ensure that such submission of
500 data is timely and [that the data is] accurate. The office may conduct an
501 audit of the data submitted [to] through such intermediary in order to
502 verify its accuracy. [Individual patient and physician data identified by
503 proper name or personal identification code submitted pursuant to this
504 section shall be kept confidential, but aggregate reports from which
505 individual patient and physician data cannot be identified shall be
506 available to the public.]

507 (c) With respect to the submission of outpatient data, an outpatient
508 surgical facility, as defined in section 19a-493b, a short-term acute care
509 general or children's hospital, or a facility that provides outpatient
510 surgical services as part of the outpatient surgery department of a
511 short-term acute care hospital shall submit to the office the data
512 identified in subsection (c) of section 19a-634. The office shall convene
513 a working group consisting of representatives of outpatient surgical
514 facilities, hospitals and other individuals necessary to develop
515 recommendations that address current obstacles to, and proposed

516 requirements for, patient-identifiable data reporting in the outpatient
517 setting. On or before February 1, 2012, the working group shall report,
518 in accordance with the provisions of section 11-4a, on its findings and
519 recommendations to the joint standing committees of the General
520 Assembly having cognizance of matters relating to public health and
521 insurance and real estate. Additional reporting of outpatient data as
522 the office deems necessary shall begin not later than July 1, 2015. On or
523 before July 1, 2012, and annually thereafter, the Connecticut
524 Association of Ambulatory Surgery Centers shall provide a progress
525 report to the Department of Public Health, until such time as all
526 ambulatory surgery centers are in full compliance with the
527 implementation of systems that allow for the reporting of outpatient
528 data as required by the commissioner. Until such additional reporting
529 requirements take effect, the department may work with the
530 Connecticut Association of Ambulatory Surgery Centers and the
531 Connecticut Hospital Association on specific data reporting initiatives
532 provided that no penalties shall be assessed under this chapter or any
533 other provision of law with respect to the failure to submit such data.

534 (d) Except as otherwise provided in this subsection, patient-
535 identifiable data received by the office shall be kept confidential and
536 shall not be considered public records or files subject to disclosure
537 under the Freedom of Information Act, as defined in section 1-200. The
538 office may release de-identified patient data or aggregate patient data
539 to the public in a manner consistent with the provisions of 45 CFR
540 164.514. Any de-identified patient data released by the office shall
541 exclude provider, physician and payer organization names or codes
542 and shall be kept confidential by the recipient. The office may not
543 release patient-identifiable data except as provided for in section 19a-
544 25 and regulations adopted pursuant to said section. No individual or
545 entity receiving patient-identifiable data may release such data in any
546 manner that may result in an individual patient, physician, provider or
547 payer being identified. The office shall impose a reasonable, cost-based
548 fee for any patient data provided to a nongovernmental entity.

549 (e) Not later than October 1, 2011, the Office of Health Care Access

550 shall enter into a memorandum of understanding with the
551 Comptroller that shall permit the Comptroller to access the data set
552 forth in subsections (b) and (c) of this section, provided the
553 Comptroller agrees, in writing, to keep individual patient and
554 physician data identified by proper name or personal identification
555 code and submitted pursuant to this section confidential.

556 (f) The Commissioner of Public Health shall adopt regulations, in
557 accordance with the provisions of chapter 54, to carry out the
558 provisions of this section.

559 (g) The duties assigned to the Department of Public Health under
560 the provisions of this section shall be implemented within available
561 appropriations.

562 Sec. 13. (NEW) (*Effective from passage*) (a) As used in this section and
563 section 14 of this act, "Affordable Care Act" means the Patient
564 Protection and Affordable Care Act, P.L. 111-148, as amended by the
565 Health Care and Education Reconciliation Act, P.L. 111-152, as both
566 may be amended from time to time, and federal regulations adopted
567 thereunder.

568 (b) There is established, in the office of the Lieutenant Governor, the
569 Office of Health Reform and Innovation. The Special Advisor to the
570 Governor on Healthcare Reform shall direct the activities of the Office
571 of Health Reform and Innovation.

572 (c) The Office of Health Reform and Innovation shall:

573 (1) Coordinate and implement the state's responsibilities under state
574 and federal health care reform;

575 (2) Identify (A) federal grants and other nonstate funding sources to
576 assist with implementing the Affordable Care Act, and (B) other
577 measures which further enhance access to health care, reduce costs and
578 improve the quality of health care in the state;

579 (3) Recommend and advance executive action and legislation to

580 effectively and efficiently implement the Affordable Care Act, and
581 state health care reform initiatives;

582 (4) Design processes to maximize stakeholder and public input and
583 ensure transparency in implementing health care reform;

584 (5) Ensure ongoing information sharing and coordination of efforts
585 with the General Assembly and state agencies concerning public health
586 and health care reform;

587 (6) Report on or after January 1, 2012, and annually thereafter, in
588 accordance with section 11-4a of the general statutes, to the joint
589 standing committees of the General Assembly having cognizance of
590 matters relating to appropriations and the budgets of state agencies,
591 human services, insurance and public health on the progress of state
592 agencies concerning implementation of the Affordable Care Act;

593 (7) Ensure coordination of efforts with state agencies concerning
594 prevention and management of chronic illnesses;

595 (8) Ensure that the structures of state government are working in
596 concert to effectively implement federal and state health care reform;

597 (9) Ensure, in consultation with the Connecticut Health Insurance
598 Exchange and the Department of Social Services, the necessary
599 coordination between said exchange and Medicaid enrollment
600 planning; and

601 (10) Maximize private philanthropic support to advance health care
602 reform initiatives.

603 (d) The Office of Health Reform and Innovation, in consultation
604 with the Sustinet Health Care Cabinet established pursuant to section
605 14 of this act, shall, on or before August 1, 2011, convene a consumer
606 advisory board that consists of not less than seven members.

607 (e) The Office of Health Reform and Innovation and the Office of the
608 Healthcare Advocate shall provide staff support to the Sustinet Health

609 Care Cabinet.

610 (f) The Office of Health Reform and Innovation shall maintain a
611 central comprehensive health reform web site.

612 (g) State agencies shall, within available appropriations, use their
613 best efforts to provide assistance to the Office of Health Reform and
614 Innovation.

615 (h) The Office of Health Reform and Innovation, in consultation
616 with the Sustinet Health Care Cabinet, may retain any consultants
617 necessary to carry out the statutory responsibilities of said office.
618 Consultants may be retained by said office for purposes that include,
619 but are not limited to, conducting feasibility and risk assessments
620 required to implement, as may be practicable, private and public
621 mechanisms to provide adequate health insurance products to
622 individuals, small employers, nonstate public employers, municipal-
623 related employers and nonprofit employers, commencing on January
624 1, 2014. Not later than October 1, 2012, the Office of Health Reform and
625 Innovation and the Sustinet Health Care Cabinet shall make
626 recommendations to the Governor based on the results of the analyses
627 undertaken pursuant to this subsection.

628 Sec. 14. (NEW) (*Effective from passage*) (a) There is established within
629 the office of the Lieutenant Governor, the Sustinet Health Care
630 Cabinet for the purpose of advising the Governor and the Office of
631 Health Reform and Innovation on the matters set forth in subsection
632 (c) of this section.

633 (b) (1) The Sustinet Health Care Cabinet shall consist of the
634 following members who shall be appointed on or before August 1,
635 2011: (A) Five appointed by the Governor, two of whom may represent
636 the health care industry and shall serve for terms of four years, one of
637 whom shall represent community health centers and shall serve for a
638 term of three years, one of whom shall represent insurance producers
639 and shall serve for a term of three years and one of whom shall be an
640 at-large appointment and shall serve for a term of three years; (B) one

641 appointed by the president pro tempore of the Senate, who shall be an
642 oral health specialist engaged in active practice and shall serve for a
643 term of four years; (C) one appointed by the majority leader of the
644 Senate, who shall represent labor and shall serve for a term of three
645 years; (D) one appointed by the minority leader of the Senate, who
646 shall be an advanced practice registered nurse engaged in active
647 practice and shall serve for a term of two years; (E) one appointed by
648 the speaker of the House of Representatives, who shall be a consumer
649 advocate and shall serve for a term of four years; (F) one appointed by
650 the majority leader of the House of Representatives, who shall be a
651 primary care physician engaged in active practice and shall serve for a
652 term of four years; (G) one appointed by the minority leader of the
653 House of Representatives, who shall represent the health information
654 technology industry and shall serve for a term of three years; (H) five
655 appointed jointly by the chairpersons of the Sustinet Health
656 Partnership board of directors, one of whom shall represent faith
657 communities, one of whom shall represent small businesses, one of
658 whom shall represent the home health care industry, one of whom
659 shall represent hospitals, and one of whom shall be an at-large
660 appointment, all of whom shall serve for terms of five years; (I) the
661 Lieutenant Governor; (J) the Secretary of the Office of Policy and
662 Management, or the secretary's designee; the Comptroller, or the
663 Comptroller's designee; the Special Advisor to the Governor on
664 Healthcare Reform, or the Special Advisor's designee; the
665 Commissioners of Social Services and Public Health, or their
666 designees; and the Healthcare Advocate, or the Healthcare Advocate's
667 designee, all of whom shall serve as ex-officio voting members; and (K)
668 the Commissioners of Children and Families, Developmental Services
669 and Mental Health and Addiction Services, and the Insurance
670 Commissioner or their designees, and the nonprofit liaison to the
671 Governor, or the nonprofit liaison's designee, all of whom shall serve
672 as ex-officio nonvoting members.

673 (2) Following the expiration of initial cabinet member terms,
674 subsequent cabinet terms shall be for four years, commencing on

675 August first of the year of the appointment. If an appointing authority
676 fails to make an initial appointment to the cabinet or an appointment
677 to fill a cabinet vacancy within ninety days of the date of such vacancy,
678 the appointed cabinet members shall, by majority vote, make such
679 appointment to the cabinet.

680 (3) Upon the expiration of the initial terms of the five cabinet
681 members appointed by SustiNet Health Partnership board of directors,
682 five successor cabinet members shall be appointed as follows: (A) One
683 appointed by the Governor; (B) one appointed by the president pro
684 tempore of the Senate; (C) one appointed by the speaker of the House
685 of Representatives; and (D) two appointed by majority vote of the
686 appointed board members. Successor board members appointed
687 pursuant to this subdivision shall be at-large appointments.

688 (4) The Lieutenant Governor shall serve as the chairperson of the
689 SustiNet Health Care Cabinet. The Lieutenant Governor shall schedule
690 the first meeting of the SustiNet Health Care Cabinet, which meeting
691 shall be held not later than September 1, 2011.

692 (c) The SustiNet Health Care Cabinet shall advise the Governor and
693 the Office of Health Reform and Innovation regarding the
694 development of an integrated health care system for Connecticut and
695 shall:

696 (1) Evaluate the means of ensuring an adequate health care
697 workforce in the state;

698 (2) Jointly evaluate, with the chief executive officer of the
699 Connecticut Health Insurance Exchange the feasibility of
700 implementing a basic health program option as set forth in Section
701 1331 of the Affordable Care Act;

702 (3) Identify short and long-range opportunities, issues and gaps
703 created by the enactment of federal health care reform;

704 (4) Coordinate with the Office of Health Reform and Innovation

705 concerning the effectiveness of delivery system reforms and other
706 efforts to control health care costs, including, but not limited to,
707 reforms and efforts implemented by state agencies;

708 (5) (A) Develop a business plan to be provided to the Governor and
709 the Office of Health Reform and Innovation that takes into account
710 feasibility and risk assessments conducted pursuant to subsection (h)
711 of section 13 of this act and evaluates private or public mechanisms
712 that will provide adequate health insurance products commencing on
713 January 1, 2014, including, but not limited to, for-profit and nonprofit
714 organizations, insurance cooperatives and self-insurance, and (B)
715 submit appropriate implementation recommendations for the
716 Governor's consideration; and

717 (6) Advise the Governor on matters relating to: (A) The design,
718 implementation, actionable objectives and evaluation of state and
719 federal health care policies, priorities and objectives relating to the
720 state's efforts to improve access to health care, and (B) the quality of
721 such care and the affordability and sustainability of the state's health
722 care system.

723 (d) The Sustinet Health Care Cabinet may convene working groups,
724 which include volunteer health care experts, to make
725 recommendations concerning the development and implementation of
726 service delivery and health care provider payment reforms, including
727 multi-payer initiatives, medical homes, electronic health records and
728 evidenced-based health care quality improvement.

729 Sec. 15. Subparagraph (B) of subdivision (15) of section 38a-816 of
730 the general statutes is repealed and the following is substituted in lieu
731 thereof (*Effective January 1, 2012*):

732 (B) Each insurer [,] or other entity responsible for providing
733 payment to a health care provider pursuant to an insurance policy
734 subject to this section, shall pay claims not later than; [forty-five]

735 (i) For claims filed in paper format, sixty days after receipt by the

736 insurer of the claimant's proof of loss form or the health care provider's
737 request for payment filed in accordance with the insurer's practices or
738 procedures, except that when there is a deficiency in the information
739 needed for processing a claim, as determined in accordance with
740 section 38a-477, the insurer shall [(i)] (I) send written notice to the
741 claimant or health care provider, as the case may be, of all alleged
742 deficiencies in information needed for processing a claim not later than
743 thirty days after the insurer receives a claim for payment or
744 reimbursement under the contract, and [(ii)] (II) pay claims for
745 payment or reimbursement under the contract not later than thirty
746 days after the insurer receives the information requested; and

747 (ii) For claims filed in electronic format, twenty days after receipt by
748 the insurer of the claimant's proof of loss form or the health care
749 provider's request for payment filed in accordance with the insurer's
750 practices or procedures, except that when there is a deficiency in the
751 information needed for processing a claim, as determined in
752 accordance with section 38a-477, the insurer shall (I) notify the
753 claimant or health care provider, as the case may be, of all alleged
754 deficiencies in information needed for processing a claim not later than
755 ten days after the insurer receives a claim for payment or
756 reimbursement under the contract, and (II) pay claims for payment or
757 reimbursement under the contract not later than ten days after the
758 insurer receives the information requested.

759 Sec. 16. Section 38a-479b of the general statutes is repealed and the
760 following is substituted in lieu thereof (*Effective January 1, 2012*):

761 (a) No contracting health organization shall make material changes
762 to a provider's fee schedule except as follows:

763 (1) At one time annually, provided providers are given at least
764 ninety days' advance notice by mail, electronic mail or facsimile by
765 such organization of any such changes. Upon receipt of such notice, a
766 provider may terminate the participating provider contract with at
767 least sixty days' advance written notice to the contracting health

768 organization;

769 (2) At any time for the following, provided providers are given at
770 least thirty days' advance notice by mail, electronic mail or facsimile by
771 such organization of any such changes:

772 (A) To comply with requirements of federal or state law, regulation
773 or policy. If such federal or state law, regulation or policy takes effect
774 in less than thirty days, the organization shall give providers as much
775 notice as possible;

776 (B) To comply with changes to the medical data code sets set forth
777 in 45 CFR 162.1002, as amended from time to time;

778 (C) To comply with changes to national best practice protocols made
779 by the National Quality Forum or other national accrediting or
780 standard-setting organization based on peer-reviewed medical
781 literature generally recognized by the relevant medical community or
782 the results of clinical trials generally recognized and accepted by the
783 relevant medical community;

784 (D) To be consistent with changes made in Medicare pertaining to
785 billing or medical management practices, provided any such changes
786 are applied to relevant participating provider contracts where such
787 changes pertain to the same specialty or payment methodology;

788 (E) If a drug, treatment, procedure or device is identified as no
789 longer safe and effective by the federal Food and Drug Administration
790 or by peer-reviewed medical literature generally recognized by the
791 relevant medical community;

792 (F) To address payment or reimbursement for a new drug,
793 treatment, procedure or device that becomes available and is
794 determined to be safe and effective by the federal Food and Drug
795 Administration or by peer-reviewed medical literature generally
796 recognized by the relevant medical community; or

797 (G) As mutually agreed to by the contracting health organization

798 and the provider. If the contracting health organization and the
799 provider do not mutually agree, the provider's current fee schedule
800 shall remain in force until the annual change permitted pursuant to
801 subdivision (1) of this subsection.

802 (b) Notwithstanding subsection (a) of this section, a contracting
803 health organization may introduce a new insurance product to a
804 provider at any time, provided such provider is given at least sixty
805 days' advance notice by mail, electronic mail or facsimile by such
806 organization if the introduction of such insurance product will make
807 material changes to the provider's administrative requirements under
808 the participating provider contract or to the provider's fee schedule.
809 The provider may decline to participate in such new product by
810 providing notice to the contracting health organization as set forth in
811 the advance notice, which shall include a period of not less than thirty
812 days for a provider to decline, or in accordance with the time frames
813 under the applicable terms of such provider's participating provider
814 contract.

815 [(b)] (c) (1) No contracting health organization shall cancel, deny or
816 demand the return of full or partial payment for an authorized covered
817 service due to administrative or eligibility error, more than eighteen
818 months after the date of the receipt of a clean claim, except if:

819 (A) Such organization has a documented basis to believe that such
820 claim was submitted fraudulently by such provider;

821 (B) The provider did not bill appropriately for such claim based on
822 the documentation or evidence of what medical service was actually
823 provided;

824 (C) Such organization has paid the provider for such claim more
825 than once;

826 (D) Such organization paid a claim that should have been or was
827 paid by a federal or state program; or

828 (E) The provider received payment for such claim from a different
829 insurer, payor or administrator through coordination of benefits or
830 subrogation, or due to coverage under an automobile insurance or
831 workers' compensation policy. Such provider shall have one year after
832 the date of the cancellation, denial or return of full or partial payment
833 to resubmit an adjusted secondary payor claim with such organization
834 on a secondary payor basis, regardless of such organization's timely
835 filing requirements.

836 (2) (A) Such organization shall give at least thirty days' advance
837 notice to a provider by mail, electronic mail or facsimile of the
838 organization's cancellation, denial or demand for the return of full or
839 partial payment pursuant to subdivision (1) of this subsection.

840 (B) If such organization demands the return of full or partial
841 payment from a provider, the notice required under subparagraph (A)
842 of this subdivision shall disclose to the provider (i) the amount that is
843 demanded to be returned, (ii) the claim that is the subject of such
844 demand, and (iii) the basis on which such return is being demanded.

845 (C) Not later than thirty days after the receipt of the notice required
846 under subparagraph (A) of this subdivision, a provider may appeal
847 such cancellation, denial or demand in accordance with the procedures
848 provided by such organization. Any demand for the return of full or
849 partial payment shall be stayed during the pendency of such appeal.

850 (D) If there is no appeal or an appeal is denied, such provider may
851 resubmit an adjusted claim, if applicable, to such organization, not
852 later than thirty days after the receipt of the notice required under
853 subparagraph (A) of this subdivision or the denial of the appeal,
854 whichever is applicable, except that if a return of payment was
855 demanded pursuant to subparagraph (C) of subdivision (1) of this
856 subsection, such claim shall not be resubmitted.

857 (E) A provider shall have one year after the date of the written
858 notice set forth in subparagraph (A) of this subdivision to identify any
859 other appropriate insurance coverage applicable on the date of service

860 and to file a claim with such insurer, health care center or other issuing
861 entity, regardless of such insurer's, health care center's or other issuing
862 entity's timely filing requirements.

863 Sec. 17. (NEW) (*Effective January 1, 2012*) Each insurer, health care
864 center, managed care organization or other entity that delivers, issues
865 for delivery, renews, amends or continues an individual or group
866 health insurance policy or medical benefits plan, and each preferred
867 provider network, as defined in section 38a-479aa of the general
868 statutes, that contracts with a health care provider, as defined in
869 section 38a-478 of the general statutes, for the purposes of providing
870 covered health care services to its enrollees, shall maintain a network
871 of such providers that is consistent with the National Committee for
872 Quality Assurance's network adequacy requirements or URAC's
873 provider network access and availability standards.

874 Sec. 18. (NEW) (*Effective January 1, 2012*) (a) (1) No insurer, health
875 care center, fraternal benefit society, hospital service corporation or
876 medical service corporation or other entity, delivering, issuing for
877 delivery, renewing, amending or continuing an individual or group
878 health insurance policy in this state providing coverage of the type
879 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
880 the general statutes or utilization review company performing
881 utilization review for such insurer, center, society, corporation or
882 entity, that preauthorizes or precertifies, on or after January 1, 2012, an
883 admission, service, procedure or extension of stay shall reverse or
884 rescind such preauthorization or precertification or refuse to pay for
885 such admission, service, procedure or extension of stay if:

886 (A) Such insurer, center, society, corporation, entity or company
887 failed to notify the insured's or enrollee's health care provider at least
888 three business days prior to the scheduled date of such admission,
889 service, procedure or extension of stay that such preauthorization or
890 precertification has been reversed or rescinded on the basis of medical
891 necessity, fraud or lack of coverage; and

892 (B) Such admission, service, procedure or extension of stay has
893 taken place in reliance on such preauthorization or precertification.

894 (2) The provisions of this subsection shall apply regardless of
895 whether such preauthorization or precertification is required or is
896 requested by an insured's or enrollee's health care provider. Unless
897 reversed or rescinded as set forth in subparagraph (A) of subdivision
898 (1) of this subsection, such preauthorization or precertification shall be
899 effective for not less than sixty days from the date of issuance.

900 (b) Nothing in subsection (a) of this section shall be construed to
901 authorize benefits or services in excess of those that are provided for in
902 the insured's or enrollee's policy or contract.

903 (c) Nothing in subsection (a) of this section shall affect the
904 provisions of subsection (b) of section 38a-479b of the general statutes.

905 Sec. 19. (NEW) (*Effective January 1, 2012*) (a) No insurer, health care
906 center, fraternal benefit society, hospital service corporation, medical
907 service corporation or other entity delivering, issuing for delivery,
908 renewing, amending or continuing an individual or group dental plan
909 in this state shall include in any contract with a dentist licensed
910 pursuant to chapter 379 of the general statutes that is entered into,
911 renewed or amended on or after January 1, 2012, shall contain any
912 provision that requires such dentist to accept as payment an amount
913 set by such insurer, center, society, corporation or entity for services or
914 procedures provided to an insured or enrollee that are not covered
915 benefits under such insured's or enrollee's plan.

916 (b) A dentist shall not charge more for services or procedures that
917 are not covered benefits than such dentist's usual and customary rate
918 for such services or procedures.

919 (c) Each evidence of coverage for an individual or group dental plan
920 shall include the following statement:

921 "IMPORTANT: If you opt to receive dental services or procedures

922 that are not covered benefits under this plan, a participating dental
923 provider may charge you his or her usual and customary rate for such
924 services or procedures. Prior to providing you with dental services or
925 procedures that are not covered benefits, the dental provider should
926 provide you with a treatment plan that includes each anticipated
927 service or procedure to be provided and the estimated cost of each
928 such service or procedure. To fully understand your coverage, you
929 may wish to review your evidence of coverage document."

930 (d) Each dentist shall post, in a conspicuous place, a notice stating
931 that services or procedures that are not covered benefits under an
932 insurance policy or plan might not be offered at a discounted rate.

933 (e) The provisions of this section shall not apply to (1) a self-insured
934 plan that covers dental services, or (2) a contract that is incorporated in
935 or derived from a collective bargaining agreement or in which some or
936 all of the material terms are subject to a collective bargaining process.

937 Sec. 20. (NEW) (*Effective October 1, 2011*) As used in sections 20 to 34,
938 inclusive, of this act:

939 (1) "Adjuster" means an independent or contracted individual who
940 investigates or settles loss claims. "Adjuster" does not include an
941 employee of an insurer who investigates or settles claims incurred
942 under insurance contracts written by the insurer or an affiliated
943 insurer.

944 (2) "Affiliate" or "affiliated" has the same meaning as provided in
945 section 38a-1 of the general statutes.

946 (3) "Business entity" means a corporation, a limited liability
947 company or any other similar form of business organization, whether
948 for profit or nonprofit.

949 (4) "Commissioner" means the Insurance Commissioner.

950 (5) "Control" or "controlled by" has the same meaning as provided
951 in section 38a-1 of the general statutes.

952 (6) "Insurance producer" has the same meaning as provided in
953 section 38a-702a of the general statutes.

954 (7) "Insurer" or "insurance company" means any person or
955 combination of persons doing any kind or form of insurance business
956 other than a fraternal benefit society, and includes a captive insurance
957 company, as defined in section 38a-91aa of the general statutes, a
958 captive insurer as defined in section 38a-91k of the general statutes, a
959 licensed insurance company, a medical service corporation, a hospital
960 service corporation, a health care center, and a consumer dental plan
961 that provides employee welfare benefits on a self-funded basis or as
962 defined in section 38a-577 of the general statutes.

963 (8) "NAIC" means the National Association of Insurance
964 Commissioners.

965 (9) "Person" has the same meaning as provided in section 38a-1 of
966 the general statutes.

967 (10) "Sell" means the exchange of an insurance contract for money or
968 other consideration, by any means, on behalf of an insurance company.

969 (11) "Third-party administrator" means any person who directly or
970 indirectly underwrites, collects premiums or charges from, or adjusts
971 or settles claims on, residents of this state in connection with life,
972 annuity or health coverage offered or provided by an insurer. "Third-
973 party administrator" does not include:

974 (A) An employer administering its employee benefit plan or the
975 benefit plan of an affiliated employer under common management and
976 control;

977 (B) A union administering a benefit plan on behalf of its members;

978 (C) An insurer that is licensed in this state or is acting as an
979 authorized insurer with respect to insurance lawfully issued to cover a
980 Connecticut resident, and sales representatives thereof;

981 (D) An insurance producer who is licensed to sell life, annuity or
982 health coverage in this state, whose activities are limited exclusively to
983 the sale of insurance;

984 (E) A creditor acting on behalf of its debtors with respect to
985 insurance covering a debt between the creditor and its debtors;

986 (F) A trust and its trustees, agents and employees acting pursuant to
987 such trust established in conformity with 29 USC Section 186, as
988 amended from time to time;

989 (G) A trust exempt from taxation under Section 501(a) of the
990 Internal Revenue Code of 1986, or any subsequent corresponding
991 internal revenue code of the United States, as amended from time to
992 time, and its trustees and employees acting pursuant to such trust, or a
993 custodian and the custodian's agents and employees acting pursuant
994 to a custodian account that meets the requirements of Section 401(f) of
995 the Internal Revenue Code of 1986, or any subsequent corresponding
996 internal revenue code of the United States, as amended from time to
997 time;

998 (H) A credit union or a financial institution that is subject to
999 supervision or examination by federal or state banking authorities, or a
1000 mortgage lender, to the extent such credit union, financial institution
1001 or mortgage lender collects or remits premiums to licensed insurance
1002 producers or limited lines producers or to authorized insurers, in
1003 connection with loan payments;

1004 (I) A credit card issuing company that advances or collects
1005 premiums or charges from its credit cardholders who have authorized
1006 collection;

1007 (J) An attorney-at-law who adjusts or settles claims in the normal
1008 course of such attorney's practice or employment and who does not
1009 collect premiums or charges in connection with life, annuity or health
1010 coverage;

1011 (K) An adjuster who is licensed in this state or is not subject to the
1012 licensure requirements of chapter 702 of the general statutes and
1013 whose activities are limited to adjusting claims;

1014 (L) An insurance producer who is licensed in this state and acting as
1015 a managing general agent, as defined in section 38a-90a of the general
1016 statutes, whose activities are limited exclusively to those specified in
1017 said section;

1018 (M) A business entity that is affiliated with an insurer licensed in
1019 this state and that undertakes activities as a third-party administrator
1020 only for the direct and assumed insurance business of the affiliated
1021 insurer;

1022 (N) A consortium of federally qualified health centers funded by the
1023 state, providing services only to the recipients of programs
1024 administered by the Department of Social Services;

1025 (O) A pharmacy benefits manager registered under section 38a-
1026 479bbb of the general statutes;

1027 (P) An entity providing administrative services to the Health
1028 Reinsurance Association established under section 38a-556 of the
1029 general statutes; or

1030 (Q) A nonprofit association or one of its direct subsidiaries that
1031 provides access to insurance as part of the benefits or services such
1032 association or subsidiary makes available to its members.

1033 (12) "Underwrites" or "underwriting" means the acceptance of
1034 employer or individual applications for coverage of individuals in
1035 accordance with the written rules of the insurer or self-funded plan,
1036 and the overall planning and coordination of a benefits program.

1037 (13) "Uniform application" means the current version of the
1038 National Association of Insurance Commissioners' Uniform
1039 Application for Third-Party Administrators.

1040 Sec. 21. (NEW) (*Effective October 1, 2011*) (a) No person shall offer to
1041 act as or hold himself out to be a third-party administrator in this state
1042 unless such person is licensed pursuant to section 30 of this act, or is
1043 exempt from licensure pursuant to subsection (b) of this section. This
1044 requirement shall not apply to a person employed by a third-party
1045 administrator to the extent that such person's activities are under the
1046 supervision and control of the third-party administrator. The authority
1047 granted to a third-party administrator pursuant to sections 20 to 29,
1048 inclusive, of this act shall not exempt such third-party administrator's
1049 employees from the licensing requirements of chapters 701b and 702 of
1050 the general statutes.

1051 (b) (1) Any insurer licensed in this state that directly or indirectly
1052 underwrites, collects premiums or charges from, or adjusts or settles
1053 claims for other than its policyholders, subscribers and certificate
1054 holders shall be exempt from sections 20 to 34, inclusive, of this act,
1055 provided such activities only involve the lines of insurance for which
1056 such insurer is licensed in this state. Any such insurer shall (A) be
1057 subject to the provisions of chapter 704 of the general statutes, (B)
1058 respond to all complaint inquiries received from the Insurance
1059 Department, not later than ten calendar days after the date a complaint
1060 is received by the insurer, and (C) with respect to any advertising that
1061 mentions any customer, obtain such customer's prior written consent.

1062 (2) Nothing in this section shall authorize the commissioner to
1063 regulate a self-insured health plan subject to the Employee Retirement
1064 Income Security Act of 1974. The commissioner is authorized to
1065 regulate those activities an insurer undertakes for the administration of
1066 a self-insured health plan that do not relate to the health benefit plan
1067 and that comport with the commissioner's statutory authority to
1068 regulate insurance and the business of insurance as provided for in 29
1069 USC 1144, as amended from time to time.

1070 (c) No third-party administrator shall act as such without a written
1071 agreement between such third-party administrator and an insurer or
1072 other person utilizing the services of the third-party administrator,

1073 which shall be retained as part of the official records of both the third-
1074 party administrator and such insurer or other person for the duration
1075 of such agreement and for five years thereafter. The agreement shall
1076 contain all provisions required by this section, except insofar as those
1077 provisions that do not apply to the activities performed by the third-
1078 party administrator.

1079 (d) The written agreement set forth in subsection (c) of this section
1080 shall include, but not be limited to:

1081 (1) A statement of activities that the third-party administrator shall
1082 undertake on behalf of the insurer or other person utilizing the services
1083 of the third-party administrator, and the lines, classes or types of
1084 insurance such third-party administrator is authorized to administer;

1085 (2) A statement of the activities and responsibilities of the third-
1086 party administrator regarding the administration of or any standards
1087 pertaining to business underwritten by the insurer, benefits, premium
1088 rates, underwriting criteria or claims payment;

1089 (3) A provision requiring the third-party administrator to render an
1090 accounting, on such frequency as the parties agree, that details all
1091 transactions performed by the third-party administrator pertaining to
1092 the business underwritten by the insurer or the business of the person
1093 utilizing the services of the third-party administrator;

1094 (4) The procedures for any withdrawals to be made by the third-
1095 party administrator from the fiduciary account established under
1096 section 26 of this act. Such procedures shall address, but not be limited
1097 to: (A) Remittance to an insurer or other person utilizing the services of
1098 the third-party administrator who is entitled to remittance, (B) deposit
1099 in an account maintained in the name of the insurer or other person
1100 utilizing the services of the third-party administrator, (C) transfer to
1101 and deposit in a claims-paying account, with claims to be paid as
1102 provided for in subsection (d) of section 26 of this act, (D) payment to a
1103 group policyholder for remittance to the insurer or other person
1104 utilizing the services of the third-party administrator entitled to such

1105 remittance, (E) payment to the third-party administrator for its
1106 commissions, fees or charges, and (F) remittance of return premiums to
1107 the person or persons entitled to such return premiums;

1108 (5) Procedures and requirements for the disclosures required to be
1109 made by the third-party administrator under section 28 of this act; and

1110 (6) A termination provision, by which either party to the written
1111 agreement may terminate such agreement for cause, that includes a
1112 procedure to resolve any disputes regarding the cause for termination
1113 of such agreement.

1114 (e) A third-party administrator or insurer or other person utilizing
1115 the services of the third-party administrator may, with written notice,
1116 terminate the written agreement for cause as provided in such written
1117 agreement. The insurer may suspend the underwriting authority of the
1118 third-party administrator during the pendency of any dispute
1119 regarding the cause for termination of the written agreement. The
1120 insurer or other person utilizing the services of the third-party
1121 administrator shall fulfill any legal obligations with respect to policies
1122 or plans affected by the written agreement, regardless of any dispute
1123 between the third-party administrator and the insurer or other person
1124 utilizing the services of the third-party administrator.

1125 Sec. 22. (NEW) (*Effective October 1, 2011*) (a) If an insurer or other
1126 person utilizes the services of a third-party administrator, the payment
1127 of any premiums or charges by or on behalf of an insured to the third-
1128 party administrator shall be deemed to have been received by the
1129 insurer or other person utilizing the services of the third-party
1130 administrator.

1131 (b) Return premium payments or claim payments forwarded by the
1132 insurer or other person utilizing the services of the third-party
1133 administrator to the third-party administrator shall not be deemed to
1134 have been paid to the insured or claimant until such payments are
1135 received by such insured or claimant.

1136 (c) Nothing in this section shall limit any right of an insurer or other
1137 person utilizing the services of a third-party administrator to bring a
1138 cause of action arising from the failure of such third-party
1139 administrator to make payments to the insurer, other person utilizing
1140 the services of the third-party administrator, insureds or claimants.

1141 Sec. 23. (NEW) (*Effective October 1, 2011*) (a) (1) Each third-party
1142 administrator shall maintain and make available to the insurer or other
1143 person utilizing the services of the third-party administrator complete
1144 books and records of all transactions performed on behalf of the
1145 insurer or other person utilizing the services of the third-party
1146 administrator. Each third-party administrator shall (A) maintain such
1147 books and records in accordance with prudent standards of insurance
1148 record keeping, and (B) retain such books and records for a period of
1149 not less than five years from the date of their creation.

1150 (2) The insurer or other person utilizing the services of a third-party
1151 administrator shall own any records generated by such third-party
1152 administrator pertaining to such insurer or other person utilizing the
1153 services of such third-party administrator. The third-party
1154 administrator shall retain the right to maintain continued access to
1155 books and records to permit the third-party administrator to fulfill all
1156 of its contractual obligations to the insurer, other person utilizing the
1157 services of the third-party administrator, insureds or claimants.

1158 (b) An insurer that is affiliated with a business entity as set forth in
1159 subparagraph (M) of subdivision (11) of section 20 of this act shall be
1160 responsible for the acts of such business entity to the extent of such
1161 business entity's activities as a third-party administrator for such
1162 insurer. Such insurer shall be responsible for furnishing the books and
1163 records of all transactions performed on behalf of the insurer to the
1164 commissioner upon the commissioner's request.

1165 (c) The commissioner shall have access for the purposes of
1166 examination, audit and inspection to books and records maintained by
1167 a third-party administrator. Any documents, materials or other

1168 information in the possession or control of the commissioner that are
1169 obtained by the commissioner from a third-party administrator,
1170 insurer, insurance producer or employee or agent thereof acting on
1171 behalf of such third-party administrator, insurer or insurance
1172 producer, in an investigation, examination or audit shall (1) be
1173 confidential by law and privileged; (2) not be subject to disclosure
1174 under section 1-210 of the general statutes; (3) not be subject to
1175 subpoena; and (4) not be subject to discovery or admissible in evidence
1176 in any private civil action. The commissioner may use such documents,
1177 materials or other information in the furtherance of any regulatory or
1178 legal action brought as a part of the commissioner's official duties.

1179 (d) Neither the commissioner nor any person who receives
1180 documents, materials or other information as set forth in subsection (c)
1181 of this section while acting under the authority of the commissioner
1182 shall testify or be required to testify in any private civil action
1183 concerning such documents, materials or information.

1184 (e) To assist the commissioner in the performance of the
1185 commissioner's duties, the commissioner may:

1186 (1) Share documents, materials or other information, including
1187 documents, materials or other information deemed confidential and
1188 privileged pursuant to subsection (c) of this section, with other state,
1189 federal and international regulatory agencies, the National Association
1190 of Insurance Commissioners or its affiliates or subsidiaries and state,
1191 federal and international law enforcement authorities, provided the
1192 recipient of such documents, materials or other information agrees to
1193 maintain the confidentiality and privileged status of such documents,
1194 materials or other information;

1195 (2) Receive documents, materials or other information, including
1196 confidential and privileged documents, materials or other information
1197 from the National Association of Insurance Commissioners or its
1198 affiliates or subsidiaries and from regulatory and law enforcement
1199 officials of foreign or domestic jurisdictions. The commissioner shall

1200 maintain as confidential or privileged any documents, materials or
1201 other information received with notice or the understanding that such
1202 documents, materials or other information are confidential or
1203 privileged under the laws of the jurisdiction that is the source of such
1204 documents, materials or other information; and

1205 (3) Enter into agreements governing the sharing and use of
1206 information consistent with this subsection.

1207 (f) No waiver of any applicable privilege or claim of confidentiality
1208 in any documents, materials or other information shall occur as a
1209 result of disclosure to the commissioner or of sharing in accordance
1210 with subsection (e) of this section.

1211 (g) Nothing in sections 20 to 34, inclusive, of this act shall prohibit
1212 the commissioner from releasing final, adjudicated actions, including
1213 for cause terminations of licenses issued to third-party administrators,
1214 to a database or other clearinghouse service maintained by the
1215 National Association of Insurance Commissioners or its affiliates or
1216 subsidiaries.

1217 (h) Notwithstanding the provisions of subparagraph (B) of
1218 subdivision (1) of subsection (a) of this section, if a written agreement
1219 set forth in subsection (c) of this section is terminated, the third-party
1220 administrator may, by a separate written agreement with the insurer
1221 or other person utilizing the services of the third-party administrator,
1222 transfer all books and records to a new third-party administrator. Such
1223 new third-party administrator shall acknowledge to the insurer or
1224 other person utilizing the services of the new third-party
1225 administrator, in writing, that the new third-party administrator shall
1226 be responsible for retaining the books and records of the prior third-
1227 party administrator as required under subparagraph (B) of subdivision
1228 (1) of subsection (a) of this section.

1229 Sec. 24. (NEW) (*Effective October 1, 2011*) A third-party administrator
1230 shall only use advertising pertaining to the business underwritten by
1231 an insurer that has been approved, in writing, by the insurer prior to

1232 its use. A third-party administrator that mentions any customer or
1233 person utilizing the services of the third-party administrator in its
1234 advertising shall obtain such customer's or person's prior written
1235 consent.

1236 Sec. 25. (NEW) (*Effective October 1, 2011*) (a) Each insurer or other
1237 person utilizing the services of a third-party administrator shall be
1238 responsible for determining the benefits, premium rates, underwriting
1239 criteria and claims payment procedures for the lines, classes or types of
1240 insurance such third-party administrator is authorized to administer,
1241 and for securing reinsurance, if any. The insurer or other person
1242 utilizing the services of a third-party administrator shall provide to
1243 such third-party administrator, in writing, procedures pertaining to
1244 such third-party administrator's administration of benefits, premium
1245 rates, underwriting criteria and claims payment. Each insurer or other
1246 person utilizing the services of a third-party administrator shall be
1247 responsible for the competent administration of such insurer's or other
1248 person's benefit and service programs.

1249 (b) If a third-party administrator administers benefits for more than
1250 one hundred certificate holders on behalf of an insurer or other person
1251 utilizing the services of a third-party administrator, such insurer or
1252 other person shall, at least semiannually, conduct a review of the
1253 operations of the third-party administrator. At least one such review
1254 shall be an on-site audit of the operations of the third-party
1255 administrator.

1256 Sec. 26. (NEW) (*Effective October 1, 2011*) (a) All premiums or charges
1257 collected by a third-party administrator on behalf of or for an insurer
1258 or other person utilizing the services of a third-party administrator,
1259 and the return of premiums received from such insurer or other
1260 person, shall be held by the third-party administrator in a fiduciary
1261 capacity. The funds shall be immediately remitted to the person
1262 entitled to them or deposited promptly in a fiduciary account
1263 established and maintained by the third-party administrator in a
1264 federal or state chartered, federally insured financial institution. The

1265 third-party administrator shall render an accounting to the insurer or
1266 other person utilizing the services of a third-party administrator that
1267 details all transactions performed by the third-party administrator
1268 pertaining to the business underwritten by the insurer or the business
1269 of the person utilizing the services of a third-party administrator.

1270 (b) Each third-party administrator that deposits in a fiduciary
1271 account charges or premiums collected on behalf of or for one or more
1272 insurers or other persons utilizing the services of the third-party
1273 administrator shall keep clear records of the deposits in and
1274 withdrawals from the account on behalf of each insurer or other
1275 person utilizing the services of the third-party administrator. The
1276 third-party administrator shall keep copies of all the records and, upon
1277 request by the insurer or other person utilizing the services of the
1278 third-party administrator, shall furnish such insurer or other person
1279 with a copy of the records of the deposits and withdrawals pertaining
1280 to such insurer or other person.

1281 (c) A third-party administrator shall not pay any claim by making
1282 withdrawals from a fiduciary account in which premiums or charges
1283 are deposited. Withdrawals from the account shall be made as
1284 provided in the written agreement set forth in subsection (c) of section
1285 21 of this act.

1286 (d) All claims paid by the third-party administrator from funds
1287 collected on behalf of or for an insurer or other person utilizing the
1288 services of the third-party administrator shall be paid only by drafts or
1289 checks of, and as authorized by, such insurer or other person.

1290 Sec. 27. (NEW) (*Effective October 1, 2011*) (a) A third-party
1291 administrator shall not enter into any written or oral agreement or
1292 understanding with an insurer or other person utilizing the services of
1293 the third-party administrator that makes or has the effect of making
1294 the amount of the third-party administrator's commissions, fees, or
1295 charges contingent upon savings effected in the adjustment, settlement
1296 or payment of losses covered by the insurer's or other person utilizing

1297 the services of the third-party administrator's obligations. This
1298 provision shall not prohibit a third-party administrator from receiving
1299 performance-based compensation for providing hospital auditing or
1300 other auditing services.

1301 (b) This section shall not prevent the compensation of a third-party
1302 administrator from being based on premiums or charges collected or
1303 the number of claims paid or processed.

1304 Sec. 28. (NEW) (*Effective October 1, 2011*) (a) When the services of a
1305 third-party administrator are utilized, such third-party administrator
1306 shall issue a benefits identification card to each insured that includes
1307 disclosure of, and relationship among, the third-party administrator,
1308 the policyholder and the insurer or other person utilizing the services
1309 of the third-party administrator.

1310 (b) When a third-party administrator collects premiums, charges or
1311 fees, the reason for collection of each item shall be identified to the
1312 insured and each item shall be shown separately. Additional charges
1313 shall not be made for services to the extent the services have been paid
1314 for by the insurer or other person utilizing the services of the third-
1315 party administrator.

1316 (c) The third-party administrator shall disclose to the insurer or
1317 other person utilizing the services of the third-party administrator all
1318 charges, fees and commissions that the third-party administrator
1319 receives arising from services it provides for the insurer or other
1320 person utilizing the services of the third-party administrator, including
1321 any fees or commissions paid by insurers providing reinsurance or
1322 stop loss coverage.

1323 Sec. 29. (NEW) (*Effective October 1, 2011*) Any policies, certificates,
1324 booklets, termination notices or other written communications
1325 delivered by an insurer or other person utilizing the services of a third-
1326 party administrator to such third-party administrator for delivery to
1327 such insurer's or other person's insureds shall be delivered by the
1328 third-party administrator promptly after receipt of instructions to

1329 deliver them from an insurer or other person utilizing the services of
1330 the third-party administrator.

1331 Sec. 30. (NEW) (*Effective October 1, 2011*) (a) (1) A third-party
1332 administrator applying for licensure shall execute a surety bond in an
1333 amount determined by the commissioner to be sufficient to protect
1334 insurers and other persons utilizing the services of the third-party
1335 administrator, but not less than the penal sum of five hundred
1336 thousand dollars. A third-party administrator licensed under this
1337 section shall maintain such surety bond as a condition for renewal of
1338 such license.

1339 (2) The commissioner may waive the requirement to execute such
1340 surety bond if the applicant submits audited annual financial
1341 statements or reports for the two most recent fiscal years that prove the
1342 applicant has a positive net worth. An audited annual financial
1343 statement or report prepared on a consolidated basis shall include a
1344 columnar consolidating or combining worksheet that shall be filed
1345 with the report and include the following: (A) Amounts shown on the
1346 consolidated audited financial report shall be shown on the worksheet,
1347 (B) amounts for each entity shall be stated separately, and (C)
1348 explanations of consolidating and eliminating entries shall be
1349 included. A third-party administrator who has submitted such
1350 statements or reports in lieu of executing a surety bond and who is
1351 renewing such administrator's license shall submit the most recent
1352 audited annual financial statement or report.

1353 (b) A third-party administrator applying for licensure shall submit
1354 an application to the commissioner by using the uniform application
1355 and paying a fee pursuant to section 38a-11 of the general statutes, as
1356 amended by this act. The uniform application shall include or be
1357 accompanied by the following information and documents: (1) All
1358 basic organizational documents of the applicant, including any articles
1359 of incorporation, articles of association, partnership agreement, trade
1360 name certificate, trust agreement, shareholder agreement and other
1361 applicable documents and all amendments to such documents; (2) the

1362 bylaws, rules, regulations or similar documents regulating the internal
1363 affairs of the applicant; (3) a NAIC biographical affidavit for the
1364 individuals responsible for the conduct of affairs of the applicant,
1365 including (A) all members of the board of directors, board of trustees,
1366 executive committee or other governing board or committee, (B) the
1367 principal officers in the case of a corporation or the partners or
1368 members in the case of a partnership, association or limited liability
1369 company, (C) any shareholders or member holding directly or
1370 indirectly ten per cent or more of the voting stock, voting securities or
1371 voting interest of the applicant, and (D) any other person who
1372 exercises control or influence over the affairs of the applicant; (4) a
1373 statement describing the business plan including information on
1374 staffing levels and activities proposed in this state and nationwide. The
1375 plan shall provide details setting forth the applicant's capability for
1376 providing a sufficient number of experienced and qualified personnel
1377 in the areas of claims processing, recordkeeping and underwriting;
1378 and (5) such other pertinent information as may be required by the
1379 commissioner.

1380 (c) A third-party administrator applying for licensure shall make
1381 available for inspection by the commissioner copies of all written
1382 agreements with insurers or other persons utilizing the services of the
1383 third-party administrator.

1384 (d) A third-party administrator applying for licensure shall produce
1385 its accounts, records and files for examination and shall make its
1386 officers available to give information with respect to its affairs, as often
1387 as is reasonably required by the commissioner.

1388 (e) The commissioner may refuse to issue a license if the
1389 commissioner determines that the third-party administrator or any
1390 individual responsible for the conduct of the affairs of the third-party
1391 administrator is not competent, trustworthy, financially responsible or
1392 of good personal and business reputation, or has had an insurance or a
1393 third-party administrator certificate of authority or license denied or
1394 revoked for cause by any jurisdiction, or if the commissioner

1395 determines that any of the grounds set forth in section 33 of this act
1396 exists with respect to the third-party administrator.

1397 (f) Any license issued to a third-party administrator shall be in force
1398 until September thirtieth of each year, unless sooner revoked or
1399 suspended as provided in this section. The license may be renewed, at
1400 the discretion of the commissioner, upon payment of the fee specified
1401 in section 38a-11 of the general statutes, as amended by this act,
1402 without the resubmission of the detailed information required in the
1403 original application.

1404 (g) A third-party administrator licensed or applying for licensure
1405 under this section shall notify the commissioner immediately of any
1406 material change in its ownership, control or other fact or circumstance
1407 affecting its qualification for a license in this state.

1408 (h) In addition to the surety bond required under subsection (a) of
1409 this section, a third-party administrator licensed or applying for a
1410 license under this section that administers or will administer
1411 governmental or church self-insured plans in this state or any other
1412 state shall execute and maintain a surety bond, for use by the
1413 commissioner and the insurance regulatory authority of any additional
1414 state in which the third-party administrator is authorized to conduct
1415 business, to cover individuals and persons who have remitted
1416 premiums, charges or fees to the third-party administrator in the
1417 course of the third-party administrator's business, in the greater of the
1418 following amounts: (1) One hundred thousand dollars; or (2) ten per
1419 cent of the aggregate total amount of self-funded coverage under
1420 governmental plans or church plans handled in this state and all
1421 additional states in which the third-party administrator is authorized
1422 to conduct business.

1423 Sec. 31. (NEW) (*Effective October 1, 2011*) A person who is not
1424 required to be licensed as a third-party administrator under
1425 subdivision (11) of section 20 or section 21 of this act and who directly
1426 or indirectly underwrites, collects charges or premiums from, or

1427 adjusts or settles claims on residents of this state, only in connection
1428 with life, annuity or health coverage provided by a self-funded plan
1429 other than governmental or church plans, shall register annually with
1430 the commissioner not later than October first on a form designated by
1431 the commissioner.

1432 Sec. 32. (NEW) (*Effective October 1, 2011*) (a) Each third-party
1433 administrator licensed under section 30 of this act shall file an annual
1434 report for the preceding calendar year with the commissioner on or
1435 before July first of each year or within such extension of time as the
1436 commissioner may grant for good cause. The annual report shall be in
1437 the form and contain such information as the commissioner prescribes,
1438 including evidence that the surety bond required under subdivision (1)
1439 of subsection (a) of this section and, if applicable, subsection (h) of
1440 section 30 of this act, remain in force. The information contained in
1441 such report shall be verified by at least two officers of the third-party
1442 administrator.

1443 (b) The annual report shall include the complete names and
1444 addresses of all insurers or other persons with which the third-party
1445 administrator had written agreements during the preceding fiscal year.

1446 (c) At the time of filing the annual report, the third-party
1447 administrator shall pay a filing fee as specified in section 38a-11 of the
1448 general statutes, as amended by this act.

1449 (d) The commissioner shall review the most recently filed annual
1450 report of each third-party administrator on or before September first of
1451 each year. Upon completion of its review, the commissioner shall: (1)
1452 Issue a certification to the third-party administrator that the annual
1453 report shows the third-party administrator is currently licensed and in
1454 good standing, or noting any deficiencies found in such annual report;
1455 or (2) update any electronic database maintained by the National
1456 Association of Insurance Commissioners, its affiliates or subsidiaries,
1457 indicating that the annual report shows the third-party administrator
1458 is compliant with existing law, or noting any deficiencies found in

1459 such annual report.

1460 Sec. 33. (NEW) (*Effective October 1, 2011*) (a) The commissioner shall
1461 suspend or revoke the license of a third-party administrator, or shall
1462 issue a cease and desist order if the third-party administrator does not
1463 have a license if, after notice and hearing, the commissioner finds that
1464 the third-party administrator: (1) Is in an unsound financial condition;
1465 (2) is using such methods or practices in the conduct of its business so
1466 as to render its further transaction of business in this state hazardous
1467 or injurious to insured persons or the public; or (3) has failed to pay
1468 any judgment rendered against it in this state within sixty days after
1469 the judgment has become final.

1470 (b) The commissioner may suspend or revoke the license of a third-
1471 party administrator, or may issue a cease and desist order if the third-
1472 party administrator does not have a license if, after notice and hearing,
1473 the commissioner finds that the third-party administrator: (1) Has
1474 violated any lawful rule or order of the commissioner or any provision
1475 of the insurance laws of this state; (2) (A) has refused to be examined
1476 or to produce its accounts, records and files for examination, or (B) if
1477 any individual responsible for the conduct of the affairs of the third-
1478 party administrator, including (i) members of the board of directors,
1479 board of trustees, executive committee or other governing board or
1480 committee, (ii) the principal officers in the case of a corporation or the
1481 partners or members in the case of a partnership, association or limited
1482 liability company, (iii) any shareholder or member holding directly or
1483 indirectly ten per cent or more of the voting stock, voting securities or
1484 voting interest of the third-party administrator, and (iv) any other
1485 person who exercises control or influence over the affairs of the third-
1486 party administrator, has refused to provide information with respect to
1487 its affairs or to perform other legal obligations as to an examination,
1488 when required by the commissioner; (3) has, without just cause,
1489 refused to pay proper claims or perform services arising under its
1490 contracts or has, without just cause, caused insureds to accept less than
1491 the amount due or caused insureds to employ attorneys or bring suit
1492 against the third-party administrator to secure full payment or

1493 settlement of such claims; (4) fails at any time to meet any qualification
1494 for which issuance of a license could have been refused had the failure
1495 then existed and been known to the commissioner; (5) has any
1496 individual who is responsible for the conduct of its affairs, including
1497 (A) members of the board of directors, board of trustees, executive
1498 committee or other governing board or committee, (B) the principal
1499 officers in the case of a corporation or the partners or members in the
1500 case of a partnership, association or limited liability company, (C) any
1501 shareholder or member holding directly or indirectly ten per cent or
1502 more of its voting stock, voting securities or voting interest, and (D)
1503 any other person who exercises control or influence over its affairs,
1504 who has been convicted of or has entered a plea of guilty or nolo
1505 contendere to a felony, without regard to whether adjudication was
1506 withheld; (6) is under suspension or revocation in another state; or (7)
1507 has failed to file a timely annual report pursuant to section 32 of this
1508 act.

1509 (c) (1) The commissioner may, without advance notice and before a
1510 hearing, issue an order immediately suspending the license of a third-
1511 party administrator, or may issue a cease and desist order if the third-
1512 party administrator does not have a license, if the commissioner finds
1513 that one or more of the following circumstances exist: (A) The third-
1514 party administrator is insolvent or impaired, (B) a proceeding for
1515 receivership, conservatorship, rehabilitation or other delinquency
1516 proceeding regarding the third-party administrator has been
1517 commenced in any state, or (C) the financial condition or business
1518 practices of the third-party administrator otherwise pose an imminent
1519 threat to the public health, safety or welfare of the residents of this
1520 state.

1521 (2) At the time the commissioner issues an order pursuant to
1522 subdivision (1) of this subsection, the commissioner shall serve notice
1523 to the third-party administrator that such third-party administrator
1524 may request a hearing not later than ten business days after the receipt
1525 of the order. If a hearing is requested, the commissioner shall schedule
1526 a hearing not later than ten business days after receipt of the request. If

1527 a hearing is not requested and the commissioner does not choose to
1528 hold one, the order shall remain in effect until modified or vacated by
1529 the commissioner.

1530 Sec. 34. (NEW) (*Effective October 1, 2011*) The Insurance
1531 Commissioner may adopt regulations, in accordance with chapter 54
1532 of the general statutes, to implement the provisions of sections 20 to 33,
1533 inclusive, of this act.

1534 Sec. 35. Subsection (a) of section 38a-15 of the general statutes is
1535 repealed and the following is substituted in lieu thereof (*Effective*
1536 *October 1, 2011*):

1537 (a) The commissioner shall, as often as [he] the commissioner deems
1538 it expedient, undertake a market conduct examination of the affairs of
1539 any insurance company, health care center, third-party administrator,
1540 as defined in section 20 of this act, or fraternal benefit society doing
1541 business in this state.

1542 Sec. 36. Subsection (a) of section 38a-11 of the general statutes is
1543 repealed and the following is substituted in lieu thereof (*Effective*
1544 *October 1, 2011*):

1545 (a) The commissioner shall demand and receive the following fees:
1546 (1) For the annual fee for each license issued to a domestic insurance
1547 company, two hundred dollars; (2) for receiving and filing annual
1548 reports of domestic insurance companies, fifty dollars; (3) for filing all
1549 documents prerequisite to the issuance of a license to an insurance
1550 company, two hundred twenty dollars, except that the fee for such
1551 filings by any health care center, as defined in section 38a-175, shall be
1552 one thousand three hundred fifty dollars; (4) for filing any additional
1553 paper required by law, thirty dollars; (5) for each certificate of
1554 valuation, organization, reciprocity or compliance, forty dollars; (6) for
1555 each certified copy of a license to a company, forty dollars; (7) for each
1556 certified copy of a report or certificate of condition of a company to be
1557 filed in any other state, forty dollars; (8) for amending a certificate of
1558 authority, two hundred dollars; (9) for each license issued to a rating

1559 organization, two hundred dollars. In addition, insurance companies
1560 shall pay any fees imposed under section 12-211; (10) a filing fee of
1561 fifty dollars for each initial application for a license made pursuant to
1562 section 38a-769; (11) with respect to insurance agents' appointments:
1563 (A) A filing fee of fifty dollars for each request for any agent
1564 appointment, except that no filing fee shall be payable for a request for
1565 agent appointment by an insurance company domiciled in a state or
1566 foreign country which does not require any filing fee for a request for
1567 agent appointment for a Connecticut insurance company; (B) a fee of
1568 one hundred dollars for each appointment issued to an agent of a
1569 domestic insurance company or for each appointment continued; and
1570 (C) a fee of eighty dollars for each appointment issued to an agent of
1571 any other insurance company or for each appointment continued,
1572 except that (i) no fee shall be payable for an appointment issued to an
1573 agent of an insurance company domiciled in a state or foreign country
1574 which does not require any fee for an appointment issued to an agent
1575 of a Connecticut insurance company, and (ii) the fee shall be twenty
1576 dollars for each appointment issued or continued to an agent of an
1577 insurance company domiciled in a state or foreign country with a
1578 premium tax rate below Connecticut's premium tax rate; (12) with
1579 respect to insurance producers: (A) An examination fee of fifteen
1580 dollars for each examination taken, except when a testing service is
1581 used, the testing service shall pay a fee of fifteen dollars to the
1582 commissioner for each examination taken by an applicant; (B) a fee of
1583 eighty dollars for each license issued; (C) a fee of eighty dollars per
1584 year, or any portion thereof, for each license renewed; and (D) a fee of
1585 eighty dollars for any license renewed under the transitional process
1586 established in section 38a-784; (13) with respect to public adjusters: (A)
1587 An examination fee of fifteen dollars for each examination taken,
1588 except when a testing service is used, the testing service shall pay a fee
1589 of fifteen dollars to the commissioner for each examination taken by an
1590 applicant; and (B) a fee of two hundred fifty dollars for each license
1591 issued or renewed; (14) with respect to casualty adjusters: (A) An
1592 examination fee of twenty dollars for each examination taken, except
1593 when a testing service is used, the testing service shall pay a fee of

1594 twenty dollars to the commissioner for each examination taken by an
1595 applicant; (B) a fee of eighty dollars for each license issued or renewed;
1596 and (C) the expense of any examination administered outside the state
1597 shall be the responsibility of the entity making the request and such
1598 entity shall pay to the commissioner two hundred dollars for such
1599 examination and the actual traveling expenses of the examination
1600 administrator to administer such examination; (15) with respect to
1601 motor vehicle physical damage appraisers: (A) An examination fee of
1602 eighty dollars for each examination taken, except when a testing
1603 service is used, the testing service shall pay a fee of eighty dollars to
1604 the commissioner for each examination taken by an applicant; (B) a fee
1605 of eighty dollars for each license issued or renewed; and (C) the
1606 expense of any examination administered outside the state shall be the
1607 responsibility of the entity making the request and such entity shall
1608 pay to the commissioner two hundred dollars for such examination
1609 and the actual traveling expenses of the examination administrator to
1610 administer such examination; (16) with respect to certified insurance
1611 consultants: (A) An examination fee of twenty-six dollars for each
1612 examination taken, except when a testing service is used, the testing
1613 service shall pay a fee of twenty-six dollars to the commissioner for
1614 each examination taken by an applicant; (B) a fee of two hundred fifty
1615 dollars for each license issued; and (C) a fee of two hundred fifty
1616 dollars for each license renewed; (17) with respect to surplus lines
1617 brokers: (A) An examination fee of twenty dollars for each
1618 examination taken, except when a testing service is used, the testing
1619 service shall pay a fee of twenty dollars to the commissioner for each
1620 examination taken by an applicant; and (B) a fee of six hundred
1621 twenty-five dollars for each license issued or renewed; (18) with
1622 respect to fraternal agents, a fee of eighty dollars for each license
1623 issued or renewed; (19) a fee of twenty-six dollars for each license
1624 certificate requested, whether or not a license has been issued; (20)
1625 with respect to domestic and foreign benefit societies shall pay: (A) For
1626 service of process, fifty dollars for each person or insurer to be served;
1627 (B) for filing a certified copy of its charter or articles of association,
1628 fifteen dollars; (C) for filing the annual report, twenty dollars; and (D)

1629 for filing any additional paper required by law, fifteen dollars; (21)
1630 with respect to foreign benefit societies: (A) For each certificate of
1631 organization or compliance, fifteen dollars; (B) for each certified copy
1632 of permit, fifteen dollars; and (C) for each copy of a report or certificate
1633 of condition of a society to be filed in any other state, fifteen dollars;
1634 (22) with respect to reinsurance intermediaries: A fee of six hundred
1635 twenty-five dollars for each license issued or renewed; (23) with
1636 respect to life settlement providers: (A) A filing fee of twenty-six
1637 dollars for each initial application for a license made pursuant to
1638 section 38a-465a; and (B) a fee of forty dollars for each license issued or
1639 renewed; (24) with respect to life settlement brokers: (A) A filing fee of
1640 twenty-six dollars for each initial application for a license made
1641 pursuant to section 38a-465a; and (B) a fee of forty dollars for each
1642 license issued or renewed; (25) with respect to preferred provider
1643 networks, a fee of two thousand seven hundred fifty dollars for each
1644 license issued or renewed; (26) with respect to rental companies, as
1645 defined in section 38a-799, a fee of eighty dollars for each permit
1646 issued or renewed; (27) with respect to medical discount plan
1647 organizations licensed under section 38a-479rr, a fee of six hundred
1648 twenty-five dollars for each license issued or renewed; (28) with
1649 respect to pharmacy benefits managers, an application fee of one
1650 hundred dollars for each registration issued or renewed; (29) with
1651 respect to captive insurance companies, as defined in section 38a-91aa,
1652 a fee of three hundred seventy-five dollars for each license issued or
1653 renewed; [and] (30) with respect to each duplicate license issued a fee
1654 of fifty dollars for each license issued; and (31) with respect to third-
1655 party administrators, as defined in section 20 of this act, (A) a fee of
1656 five hundred dollars for each license issued, (B) a fee of three hundred
1657 fifty dollars for each license renewed, and (C) a fee of one hundred
1658 dollars for each annual report filed pursuant to section 32 of this act.

1659 Sec. 37. Section 38a-497 of the general statutes is repealed and the
1660 following is substituted in lieu thereof (*Effective from passage*):

1661 [Every] Each individual health insurance policy providing coverage
1662 of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12)

1663 of section 38a-469 delivered, issued for delivery, amended, renewed or
1664 continued in this state shall provide that coverage of a child shall
1665 terminate no earlier than the policy anniversary date on or after
1666 whichever of the following occurs first, the date on which the child:
1667 [Marries; ceases to be a resident of the state; becomes] Becomes
1668 covered under a group health plan through the dependent's own
1669 employment; or attains the age of twenty-six. [The residency
1670 requirement shall not apply to dependent children under nineteen
1671 years of age or full-time students attending an accredited institution of
1672 higher education.] Each such policy shall cover a stepchild on the same
1673 basis as a biological child.

1674 Sec. 38. (NEW) (*Effective from passage*) Each group health insurance
1675 policy providing coverage of the type specified in subdivisions (1), (2),
1676 (4), (6), (10), (11) and (12) of section 38a-469 of the general statutes
1677 delivered, issued for delivery, amended, renewed or continued in this
1678 state shall provide that coverage of a child shall terminate no earlier
1679 than the policy anniversary date on or after whichever of the following
1680 occurs first, the date on which the child: Becomes covered under a
1681 group health plan through the dependent's own employment; or
1682 attains the age of twenty-six. Each such policy shall cover a stepchild
1683 on the same basis as a biological child.

1684 Sec. 39. Subsection (a) of section 5-259 of the general statutes is
1685 repealed and the following is substituted in lieu thereof (*Effective from*
1686 *passage*):

1687 (a) The Comptroller, with the approval of the Attorney General and
1688 of the Insurance Commissioner, shall arrange and procure a group
1689 hospitalization and medical and surgical insurance plan or plans for
1690 (1) state employees, (2) members of the General Assembly who elect
1691 coverage under such plan or plans, (3) participants in an alternate
1692 retirement program who meet the service requirements of section
1693 5-162 or subsection (a) of section 5-166, (4) anyone receiving benefits
1694 under section 5-144 or from any state-sponsored retirement system,
1695 except the teachers' retirement system and the municipal employees

1696 retirement system, (5) judges of probate and Probate Court employees,
1697 (6) the surviving spouse, and any dependent children [until they reach
1698 the age of eighteen,] of a state police officer, a member of an organized
1699 local police department, a firefighter or a constable who performs
1700 criminal law enforcement duties who dies before, on or after June 26,
1701 2003, as the result of injuries received while acting within the scope of
1702 such officer's or firefighter's or constable's employment and not as the
1703 result of illness or natural causes, and whose surviving spouse and
1704 dependent children are not otherwise eligible for a group
1705 hospitalization and medical and surgical insurance plan. Coverage for
1706 a dependent child pursuant to this subdivision shall terminate no
1707 earlier than the policy anniversary date on or after whichever of the
1708 following occurs first, the date on which the child: Becomes covered
1709 under a group health plan through the dependent's own employment;
1710 or attains the age of twenty-six, (7) employees of the Capital City
1711 Economic Development Authority established by section 32-601, and
1712 (8) the surviving spouse and dependent children of any employee of a
1713 municipality who dies on or after October 1, 2000, as the result of
1714 injuries received while acting within the scope of such employee's
1715 employment and not as the result of illness or natural causes, and
1716 whose surviving spouse and dependent children are not otherwise
1717 eligible for a group hospitalization and medical and surgical insurance
1718 plan. For purposes of this subdivision, "employee" means any regular
1719 employee or elective officer receiving pay from a municipality,
1720 "municipality" means any town, city, borough, school district, taxing
1721 district, fire district, district department of health, probate district,
1722 housing authority, regional work force development board established
1723 under section 31-3k, flood commission or authority established by
1724 special act or regional planning agency. For purposes of subdivision
1725 (6) of this subsection, "firefighter" means any person who is regularly
1726 employed and paid by any municipality for the purpose of performing
1727 firefighting duties for a municipality on average of not less than thirty-
1728 five hours per week. The minimum benefits to be provided by such
1729 plan or plans shall be substantially equal in value to the benefits that
1730 each such employee or member of the General Assembly could secure

1731 in such plan or plans on an individual basis on the preceding first day
1732 of July. The state shall pay for each such employee and each member
1733 of the General Assembly covered by such plan or plans the portion of
1734 the premium charged for such member's or employee's individual
1735 coverage and seventy per cent of the additional cost of the form of
1736 coverage and such amount shall be credited to the total premiums
1737 owed by such employee or member of the General Assembly for the
1738 form of such member's or employee's coverage under such plan or
1739 plans. On and after January 1, 1989, the state shall pay for anyone
1740 receiving benefits from any such state-sponsored retirement system
1741 one hundred per cent of the portion of the premium charged for such
1742 member's or employee's individual coverage and one hundred per
1743 cent of any additional cost for the form of coverage. The balance of any
1744 premiums payable by an individual employee or by a member of the
1745 General Assembly for the form of coverage shall be deducted from the
1746 payroll by the State Comptroller. The total premiums payable shall be
1747 remitted by the Comptroller to the insurance company or companies
1748 or nonprofit organization or organizations providing the coverage. The
1749 amount of the state's contribution per employee for a health
1750 maintenance organization option shall be equal, in terms of dollars and
1751 cents, to the largest amount of the contribution per employee paid for
1752 any other option that is available to all eligible state employees
1753 included in the health benefits plan, but shall not be required to exceed
1754 the amount of the health maintenance organization premium.

1755 Sec. 40. Subsection (f) of section 5-259 of the general statutes is
1756 repealed and the following is substituted in lieu thereof (*Effective from*
1757 *passage*):

1758 (f) The Comptroller, with the approval of the Attorney General and
1759 of the Insurance Commissioner, shall arrange and procure a group
1760 hospitalization and medical and surgical insurance plan or plans for
1761 any person who adopts a child from the state foster care system, any
1762 person who has been a foster parent for the Department of Children
1763 and Families for six months or more, a parent in a permanent family
1764 residence for six months or more, and any dependent of such adoptive

parent, foster parent or parent in a permanent family residence who elects coverage under such plan or plans. The Comptroller may also arrange for inclusion of such person and any such dependent in an existing group hospitalization and medical and surgical insurance plan offered by the state. Any adoptive parent, foster parent or a parent in a permanent family residence and any dependent who elects coverage shall pay one hundred per cent of the premium charged for such coverage directly to the insurer, provided such adoptive parent, foster parent or parent and all such dependents shall be included in such group hospitalization and medical and surgical insurance plan. A person and his dependents electing coverage pursuant to this subsection shall be eligible for such coverage until no longer an adoptive parent, a foster parent or a parent in a permanent family residence. An adoptive parent shall be eligible for such coverage until the [adopted child reaches the age of eighteen or, if the child has not completed a secondary education program, until such child reaches the age of twenty-one] coverage anniversary date on or after whichever of the following occurs first, the date on which the child:
Becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six. As used in this section "dependent" means a spouse or natural or adopted child if such child is wholly or partially dependent for support upon the adoptive parent, foster parent or parent in a permanent family residence.

Sec. 41. Subsection (b) of section 38a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) (1) No group health insurance plan or insurance arrangement shall impose a preexisting conditions provision that excludes coverage for (A) individuals eighteen years of age and younger, or (B) a period beyond twelve months following the insured's effective date of coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the six months immediately preceding the effective date of coverage.

1799 (2) No individual health insurance plan or insurance arrangement
1800 shall impose a preexisting conditions provision that excludes coverage
1801 for (A) individuals eighteen years of age and younger, or (B) a period
1802 beyond twelve months following the insured's effective date of
1803 coverage. Any preexisting conditions provision shall only relate to
1804 conditions, whether physical or mental, for which medical advice,
1805 diagnosis or care or treatment was recommended or received during
1806 the twelve months immediately preceding the effective date of
1807 coverage.

1808 (3) No insurance company, fraternal benefit society, hospital service
1809 corporation, medical service corporation or health care center shall
1810 refuse to issue an individual health insurance plan or insurance
1811 arrangement to individuals eighteen years of age and younger solely
1812 on the basis that an individual has a preexisting condition.

1813 Sec. 42. (NEW) (*Effective from passage*) (a) No individual health
1814 insurance policy providing coverage of the type specified in
1815 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
1816 statutes delivered, issued for delivery, amended, renewed or
1817 continued in this state shall include a lifetime limit on the dollar value
1818 of benefits for a covered individual, for covered benefits that are
1819 essential health benefits, as defined in the Patient Protection and
1820 Affordable Care Act, P.L. 111-1448, as amended from time to time, or
1821 regulations adopted thereunder.

1822 (b) This section shall not prohibit the inclusion of a lifetime limit on
1823 specific covered benefits that are not essential health benefits, provided
1824 the lifetime limit for reasonable charges or, when applicable, the
1825 allowance agreed upon by a health care provider and an insurer,
1826 health care center, hospital service corporation, medical service
1827 corporation or fraternal benefit society for charges actually incurred
1828 for any specific covered benefit, shall be not less than one million
1829 dollars per covered individual.

1830 Sec. 43. (NEW) (*Effective from passage*) (a) No group health insurance

1831 policy providing coverage of the type specified in subdivisions (1), (2),
1832 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
1833 issued for delivery, amended, renewed or continued in this state shall
1834 include a lifetime limit on the dollar value of benefits for a covered
1835 individual, for covered benefits that are essential health benefits, as
1836 defined in the Patient Protection and Affordable Care Act, P.L. 111-
1837 1448, as amended from time to time, or regulations adopted
1838 thereunder.

1839 (b) This section shall not prohibit the inclusion of a lifetime limit on
1840 specific covered benefits that are not essential health benefits, provided
1841 the lifetime limit for reasonable charges or, when applicable, the
1842 allowance agreed upon by a health care provider and an insurer,
1843 health care center, hospital service corporation, medical service
1844 corporation or fraternal benefit society for charges actually incurred
1845 for any specific covered benefit, shall be not less than one million
1846 dollars per covered individual.

1847 Sec. 44. (NEW) (*Effective from passage*) (a) (1) Each insurer, health
1848 care center, hospital service corporation, medical service corporation,
1849 fraternal benefit society or other entity delivering, issuing for delivery,
1850 renewing, amending or continuing a group health insurance policy in
1851 this state that provides coverage of the type specified in subdivisions
1852 (1), (2), (3), (4), (11) and (12) of section 38a-469 of the general statutes
1853 shall provide the option to continue coverage under each of the
1854 following circumstances until the individual is eligible for other group
1855 insurance, except as provided in subparagraphs (C) and (D) of this
1856 subdivision:

1857 (A) Upon layoff, reduction of hours, leave of absence or termination
1858 of employment, other than as a result of death of the employee or as a
1859 result of such employee's "gross misconduct" as that term is used in 29
1860 USC 1163(2), continuation of coverage for such employee and such
1861 employee's covered dependents for a period of thirty months after the
1862 date of such layoff, reduction of hours, leave of absence or termination
1863 of employment, except that if such reduction of hours, leave of absence

1864 or termination of employment results from an employee's eligibility to
1865 receive Social Security income, continuation of coverage for such
1866 employee and such employee's covered dependents until midnight of
1867 the day preceding such person's eligibility for benefits under Title
1868 XVIII of the Social Security Act;

1869 (B) Upon the death of the employee, continuation of coverage for
1870 the covered dependents of such employee for the periods set forth for
1871 such event under federal extension requirements established by the
1872 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
1873 as amended from time to time;

1874 (C) Regardless of the employee's or dependent's eligibility for other
1875 group insurance, during an employee's absence due to illness or injury,
1876 continuation of coverage for such employee and such employee's
1877 covered dependents during continuance of such illness or injury or for
1878 up to twelve months from the beginning of such absence;

1879 (D) Regardless of an individual's eligibility for other group
1880 insurance, upon termination of the group policy, coverage for covered
1881 individuals who were totally disabled on the date of termination shall
1882 be continued without premium payment during the continuance of
1883 such disability for a period of twelve calendar months following the
1884 calendar month in which such policy was terminated, provided claim
1885 is submitted for coverage within one year of the termination of such
1886 policy;

1887 (E) The coverage of any covered individual shall terminate: (i) As to
1888 a child, (I) as set forth in section 38 of this act. If on the date specified
1889 for termination of coverage on a child, the child is incapable of self-
1890 sustaining employment by reason of mental or physical handicap and
1891 chiefly dependent upon the employee for support and maintenance,
1892 the coverage on such child shall continue while the plan remains in
1893 force and the child remains in such condition, provided proof of such
1894 handicap is received by such insurer, center, corporation, society or
1895 other entity within thirty-one days of the date on which the child's

1896 coverage would have terminated in the absence of such incapacity.
1897 Such insurer, center, corporation, society or other entity may require
1898 subsequent proof of the child's continued incapacity and dependency
1899 but not more often than once a year thereafter, or (II) for the periods
1900 set forth for such child under federal extension requirements
1901 established by the Consolidated Omnibus Budget Reconciliation Act of
1902 1985, P.L. 99-272, as amended from time to time; (ii) as to the
1903 employee's spouse, at the end of the month following the month in
1904 which a divorce, court-ordered annulment or legal separation is
1905 obtained, whichever is earlier, except that the plan shall provide the
1906 option for said spouse to continue coverage for the periods set forth for
1907 such events under federal extension requirements established by the
1908 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
1909 as amended from time to time; and (iii) as to the employee or
1910 dependent who is sixty-five years of age or older, as of midnight of the
1911 day preceding such person's eligibility for benefits under Title XVIII of
1912 the federal Social Security Act;

1913 (F) As to any other event listed as a "qualifying event" in 29 USC
1914 1163, as amended from time to time, continuation of coverage for such
1915 periods set forth for such event in 29 USC 1162, as amended from time
1916 to time, provided such plan may require the individual whose
1917 coverage is to be continued to pay up to the percentage of the
1918 applicable premium as specified for such event in 29 USC 1162, as
1919 amended from time to time.

1920 (2) Any continuation of coverage required by this subsection except
1921 subparagraph (D) or (F) of subdivision (1) of this subsection may be
1922 subject to the requirement, on the part of the individual whose
1923 coverage is to be continued, that such individual contribute that
1924 portion of the premium the individual would have been required to
1925 contribute had the employee remained an active covered employee,
1926 except that the individual may be required to pay up to one hundred
1927 two per cent of the entire premium at the group rate if coverage is
1928 continued in accordance with subparagraph (A), (B) or (E) of
1929 subdivision (1) of this subsection. The employer shall not be legally

1930 obligated by sections 38a-505 or 38a-546, as amended by this act, of the
1931 general statutes to pay such premium if not paid timely by the
1932 employee.

1933 (b) The plan shall make available to Connecticut residents, in
1934 addition to any other conversion privilege available, a conversion
1935 privilege under which coverage shall be available immediately upon
1936 termination of coverage under the group policy. The terms and
1937 benefits offered under the conversion benefits shall be at least equal to
1938 the terms and benefits of an individual health insurance policy.

1939 (c) Nothing in this section shall alter or impair existing group
1940 policies which have been established pursuant to an agreement which
1941 resulted from collective bargaining, and the provisions required by
1942 this section shall become effective upon the next regular renewal and
1943 completion of such collective bargaining agreement.

1944 Sec. 45. Section 38a-546 of the general statutes is repealed and the
1945 following is substituted in lieu thereof (*Effective from passage*):

1946 [(a) In order to assure reasonable continuation of coverage and
1947 extension of benefits to the citizens of this state, each group health
1948 insurance policy, regardless of the number of insureds, providing
1949 coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and
1950 (12) of section 38a-469, delivered, issued for delivery, renewed,
1951 amended or continued in this state shall, subject to the provisions of
1952 subsection (d), contain those provisions described in subsections (b)
1953 and (d) of section 38a-554.]

1954 [(b)] (a) In any case of the discontinuance of a group health
1955 insurance policy providing coverage of the type specified in
1956 subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 and
1957 delivered, issued for delivery, renewed, amended or continued in this
1958 state and the subsequent replacement of such coverage with another
1959 such policy, the succeeding carrier, in applying any deductible,
1960 coinsurance or waiting period provisions in its plan, shall give credit
1961 for the satisfaction or partial satisfaction of the same or similar

1962 provisions under a prior plan providing similar benefits. In the case of
1963 deductible or coinsurance provisions, the credit shall apply for the
1964 same or overlapping benefit periods and shall be given for expenses
1965 actually incurred and applied against the deductible or coinsurance
1966 provisions of the prior carrier's plan during the ninety days preceding
1967 the effective date of the succeeding carrier's plan but only to the extent
1968 these expenses are recognized under the terms of the succeeding
1969 carrier's plan and are subject to a similar deductible or coinsurance
1970 provision.

1971 [(c)] (b) The commissioner shall adopt regulations in accordance
1972 with the provisions of chapter 54, covering group coverage
1973 discontinuance and replacement.

1974 [(d)] (c) Nothing in this section shall alter or impair existing group
1975 policies which have been established pursuant to an agreement which
1976 resulted from collective bargaining, and the provisions required by
1977 this section shall become effective upon the next regular renewal and
1978 completion of such collective bargaining agreement.

1979 Sec. 46. Subdivision (17) of section 38a-564 of the general statutes is
1980 repealed and the following is substituted in lieu thereof (*Effective from*
1981 *passage*):

1982 (17) "Preexisting conditions provision" means a policy provision
1983 [which] that excludes coverage for charges or expenses incurred
1984 during a specified period following the insured's effective date of
1985 coverage as to a condition [which] that, during a specified period
1986 immediately preceding the effective date of coverage, had manifested
1987 itself in such a manner as would cause an ordinary prudent person to
1988 seek diagnosis, care or treatment or for which medical advice,
1989 diagnosis, care or treatment was recommended or received as to that
1990 condition, [or as to a condition which is pregnancy existing on the
1991 effective date of coverage.]

1992 Sec. 47. Subsection (b) of section 38a-477b of the general statutes is
1993 repealed and the following is substituted in lieu thereof (*Effective from*

1994 *passage*):

1995 (b) An insurer or health care center shall apply for approval of such
1996 rescission, cancellation or limitation by submitting such written
1997 information to the Insurance Commissioner on an application in such
1998 form as the commissioner prescribes. Such insurer or health care center
1999 shall provide a copy of the application for such approval to the insured
2000 or the insured's representative. Not later than seven business days
2001 after receipt of the application for such approval, the insured or the
2002 insured's representative shall have an opportunity to review such
2003 application and respond and submit relevant information to the
2004 commissioner with respect to such application. Not later than fifteen
2005 business days after the submission of information by the insured or the
2006 insured's representative, the commissioner shall issue a written
2007 decision on such application. The commissioner [may] shall only
2008 approve; [such rescission, cancellation]

2009 (1) Such rescission or limitation if the commissioner finds that [(1)]
2010 (A) the insured or such insured's representative submitted the written
2011 information [submitted] on or with the insurance application that was
2012 [false] fraudulent at the time such application was made, [and] (B) the
2013 insured or such insured's representative [knew or should have known
2014 of the falsity] intentionally misrepresented information therein [,] and
2015 such [submission] misrepresentation materially affects the risk or the
2016 hazard assumed by the insurer or health care center, or [(2)] (C) the
2017 information omitted from the insurance application was [knowingly]
2018 intentionally omitted by the insured or such insured's representative [,
2019 or the insured or such insured's representative should have known of
2020 such omission,] and such omission materially affects the risk or the
2021 hazard assumed by the insurer or health care center. Such decision
2022 shall be mailed to the insured, the insured's representative, if any, and
2023 the insurer or health care center; and

2024 (2) Such cancellation in accordance with the provisions set forth in
2025 the Public Health Service Act, 42 USC 300gg et seq., as amended from
2026 time to time.

2027 Sec. 48. Subparagraph (D) of subdivision (1) of section 38a-567 of the
2028 general statutes is repealed and the following is substituted in lieu
2029 thereof (*Effective from passage*):

2030 (D) Notwithstanding the provisions of this subdivision, any such
2031 plan or arrangement, or any coverage provided under such plan or
2032 arrangement may be rescinded for fraud, intentional material
2033 misrepresentation or concealment by an applicant, employee,
2034 dependent or small employer.

2035 Sec. 49. Subsection (b) of section 38a-478l of the general statutes is
2036 repealed and the following is substituted in lieu thereof (*Effective*
2037 *January 1, 2012*):

2038 (b) (1) The consumer report card shall be known as the "Consumer
2039 Report Card on Health Insurance Carriers in Connecticut" and shall
2040 include [(1)] (A) all health care centers licensed pursuant to chapter
2041 698a, [(2)] (B) the fifteen largest licensed health insurers that use
2042 provider networks and that are not included in [subdivision (1)]
2043 subparagraph (A) of this [subsection] subdivision, [(3)] (C) the state
2044 medical loss ratio of each such health care center or licensed health
2045 insurer, [(4)] (D) the federal medical loss ratio of each such health care
2046 center or licensed health insurer, (E) the information required under
2047 subdivision (6) of subsection (a) of section 38a-478c, as amended by
2048 this act, and [(5)] (F) information concerning mental health services, as
2049 specified in subsection (c) of this section. The insurers selected
2050 pursuant to [subdivision (2)] subparagraph (B) of this [subsection]
2051 subdivision shall be selected on the basis of Connecticut direct written
2052 health premiums from such network plans.

2053 (2) For the purposes of this section and sections 38a-477c, 38a-478c
2054 and 38a-478g, as amended by this act: ["medical"]

2055 (A) "State medical loss ratio" means the ratio of incurred claims to
2056 earned premiums for the prior calendar year for managed care plans
2057 issued in the state. Claims shall be limited to medical expenses for
2058 services and supplies provided to enrollees and shall not include

2059 expenses for stop loss coverage, reinsurance, enrollee educational
2060 programs or other cost containment programs or features;

2061 (B) "Federal medical loss ratio" has the same meaning as provided
2062 in, and shall be calculated in accordance with, the Patient Protection
2063 and Affordable Care Act, P.L. 111-148, as amended from time to time,
2064 and regulations adopted thereunder.

2065 Sec. 50. Section 38a-477c of the general statutes is repealed and the
2066 following is substituted in lieu thereof (*Effective January 1, 2012*):

2067 An insurer or health care center shall include a written notice with
2068 each application for individual or group health insurance coverage
2069 that discloses such insurer's or health care center's state medical loss
2070 ratio and federal medical loss ratio, as both terms are defined in
2071 [subsection (b) of] section 38a-478l, as amended by this act, as reported
2072 in the last Consumer Report Card on Health Insurance Carriers in
2073 Connecticut, to an applicant at the time of application for coverage.

2074 Sec. 51. Section 38a-478c of the general statutes is repealed and the
2075 following is substituted in lieu thereof (*Effective January 1, 2012*):

2076 (a) On or before May first of each year, each managed care
2077 organization shall submit to the commissioner:

2078 (1) A report on its quality assurance plan that includes, but is not
2079 limited to, information on complaints related to providers and quality
2080 of care, on decisions related to patient requests for coverage and on
2081 prior authorization statistics. Statistical information shall be submitted
2082 in a manner permitting comparison across plans and shall include, but
2083 not be limited to: (A) The ratio of the number of complaints received to
2084 the number of enrollees; (B) a summary of the complaints received
2085 related to providers and delivery of care or services and the action
2086 taken on the complaint; (C) the ratio of the number of prior
2087 authorizations denied to the number of prior authorizations requested;
2088 (D) the number of utilization review determinations made by or on
2089 behalf of a managed care organization not to certify an admission,

2090 service, procedure or extension of stay, and the denials upheld and
2091 reversed on appeal within the managed care organization's utilization
2092 review procedure; (E) the percentage of those employers or groups
2093 that renew their contracts within the previous twelve months; and (F)
2094 notwithstanding the provisions of this subsection, on or before July
2095 first of each year, all data required by the National Committee for
2096 Quality Assurance (NCQA) for its Health Plan Employer Data and
2097 Information Set (HEDIS). If an organization does not provide
2098 information for the National Committee for Quality Assurance for its
2099 Health Plan Employer Data and Information Set, then it shall provide
2100 such other equivalent data as the commissioner may require by
2101 regulations adopted in accordance with the provisions of chapter 54.
2102 The commissioner shall find that the requirements of this subdivision
2103 have been met if the managed care plan has received a one-year or
2104 higher level of accreditation by the National Committee for Quality
2105 Assurance and has submitted the Health Plan Employee Data
2106 Information Set data required by subparagraph (F) of this subdivision.

2107 (2) A model contract that contains the provisions currently in force
2108 in contracts between the managed care organization and preferred
2109 provider networks in this state, and the managed care organization
2110 and participating providers in this state and, upon the commissioner's
2111 request, a copy of any individual contracts between such parties,
2112 provided the contract may withhold or redact proprietary fee schedule
2113 information; [.]

2114 (3) A written statement of the types of financial arrangements or
2115 contractual provisions that the managed care organization has with
2116 hospitals, utilization review companies, physicians, preferred provider
2117 networks and any other health care providers including, but not
2118 limited to, compensation based on a fee-for-service arrangement, a
2119 risk-sharing arrangement or a capitated risk arrangement; [.]

2120 (4) Such information as the commissioner deems necessary to
2121 complete the consumer report card required pursuant to section 38a-
2122 478l, as amended by this act. Such information may include, but need

2123 not be limited to: (A) The organization's characteristics, including its
2124 model, its profit or nonprofit status, its address and telephone number,
2125 the length of time it has been licensed in this and any other state, its
2126 number of enrollees and whether it has received any national or
2127 regional accreditation; (B) a summary of the information required by
2128 subdivision (3) of this section, including any change in a plan's rates
2129 over the prior three years, its state medical loss ratio and its federal
2130 medical loss ratio, as both terms are defined in [subsection (b) of]
2131 section 38a-478l, as amended by this act, how it compensates health
2132 care providers and its premium level; (C) a description of services, the
2133 number of primary care physicians and specialists, the number and
2134 nature of participating preferred provider networks and the
2135 distribution and number of hospitals, by county; (D) utilization review
2136 information, including the name or source of any established medical
2137 protocols and the utilization review standards; (E) medical
2138 management information, including the provider-to-patient ratio by
2139 primary care provider and specialty care provider, the percentage of
2140 primary and specialty care providers who are board certified, and how
2141 the medical protocols incorporate input as required in section 38a-
2142 478e; (F) the quality assurance information required to be submitted
2143 under the provisions of subdivision (1) of subsection (a) of this section;
2144 (G) the status of the organization's compliance with the reporting
2145 requirements of this section; (H) whether the organization markets to
2146 individuals and Medicare recipients; (I) the number of hospital days
2147 per thousand enrollees; and (J) the average length of hospital stays for
2148 specific procedures, as may be requested by the commissioner; [.]

2149 (5) A summary of the procedures used by managed care
2150 organizations to credential providers; and [.]

2151 (6) A report on claims denial data for lives covered in the state for
2152 the prior calendar year, in a format prescribed by the commissioner,
2153 that includes: (A) The total number of claims received; (B) the total
2154 number of claims denied; (C) the total number of denials that were
2155 appealed; (D) the total number of denials that were reversed upon
2156 appeal; (E) (i) the reasons for the denials, including, but not limited to,

2157 "not a covered benefit", "not medically necessary" and "not an eligible
2158 enrollee", (ii) the total number of times each reason was used, and (iii)
2159 the percentage of the total number of denials each reason was used;
2160 and (F) other information the commissioner deems necessary.

2161 (b) The information required pursuant to subsection (a) of this
2162 section shall be consistent with the data required by the National
2163 Committee for Quality Assurance (NCQA) for its Health Plan
2164 Employer Data and Information Set (HEDIS).

2165 (c) The commissioner may accept electronic filing for any of the
2166 requirements under this section.

2167 (d) No managed care organization shall be liable for a claim arising
2168 out of the submission of any information concerning complaints
2169 concerning providers, provided the managed care organization
2170 submitted the information in good faith.

2171 (e) The information required under subdivision (6) of subsection (a)
2172 of this section shall be posted on the Insurance Department's Internet
2173 web site.

2174 Sec. 52. Subsection (b) of section 38a-478g of the general statutes is
2175 repealed and the following is substituted in lieu thereof (*Effective*
2176 *January 1, 2012*):

2177 (b) Each managed care organization shall provide every enrollee
2178 with a plan description. The plan description shall be in plain language
2179 as commonly used by the enrollees and consistent with chapter 699a.
2180 The plan description shall be made available to each enrollee and
2181 potential enrollee prior to the enrollee's entering into the contract and
2182 during any open enrollment period. The plan description shall not
2183 contain provisions or statements that are inconsistent with the plan's
2184 medical protocols. The plan description shall contain:

2185 (1) A clear summary of the provisions set forth in subdivisions (1) to
2186 (12), inclusive, of subsection (a) of this section, subdivision (3) of

2187 subsection (a) of section 38a-478c and sections 38a-478j to 38a-478l,
2188 inclusive, as amended by this act;

2189 (2) A statement of the number of managed care organization's
2190 utilization review determinations not to certify an admission, service,
2191 procedure or extension of stay, and the denials upheld and reversed on
2192 appeal within the managed care organization's utilization review
2193 procedure;

2194 (3) A description of emergency services, the appropriate use of
2195 emergency services, including to the use of E 9-1-1 telephone systems,
2196 any cost sharing applicable to emergency services and the location of
2197 emergency departments and other settings in which participating
2198 physicians and hospitals provide emergency services and post
2199 stabilization care;

2200 (4) Coverage of the plans, including exclusions of specific
2201 conditions, ailments or disorders;

2202 (5) The use of drug formularies or any limits on the availability of
2203 prescription drugs and the procedure for obtaining information on the
2204 availability of specific drugs covered;

2205 (6) The number, types and specialties and geographic distribution of
2206 direct health care providers;

2207 (7) Participating and nonparticipating provider reimbursement
2208 procedure;

2209 (8) Preauthorization and utilization review requirements and
2210 procedures, internal grievance procedures and internal and external
2211 complaint procedures;

2212 (9) The state medical loss ratio and the federal medical loss ratio, as
2213 both terms are defined in [subsection (b) of] section 38a-478l, as
2214 amended by this act, as reported in the last Consumer Report Card on
2215 Health Insurance Carriers in Connecticut;

2216 (10) The plan's for-profit, nonprofit incorporation and ownership
2217 status;

2218 (11) Telephone numbers for obtaining further information,
2219 including the procedure for enrollees to contact the organization
2220 concerning coverage and benefits, claims grievance and complaint
2221 procedures after normal business hours;

2222 (12) How notification is provided to an enrollee when the plan is no
2223 longer contracting with an enrollee's primary care provider;

2224 (13) The procedures for obtaining referrals to specialists or for
2225 consulting a physician other than the primary care physician;

2226 (14) The status of the National Committee for Quality Assurance
2227 (NCQA) accreditation;

2228 (15) Enrollee satisfaction information; and

2229 (16) Procedures for protecting the confidentiality of medical records
2230 and other patient information.

2231 Sec. 53. (NEW) (*Effective from passage*) (a) For purposes of this
2232 section, "Affordable Care Act" means the Patient Protection and
2233 Affordable Care Act, P.L. 111-148, as amended from time to time, and
2234 regulations adopted thereunder.

2235 (b) Each insurance company, fraternal benefit society, hospital
2236 service corporation, medical service corporation and health care center
2237 licensed to do business in the state shall comply with Sections 1251,
2238 1252 and 1304 of the Affordable Care Act and the following Sections of
2239 the Public Health Service Act, as amended by the Affordable Care Act:
2240 (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A,
2241 inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

2242 (c) This section shall apply, on and after the effective dates specified
2243 in the Affordable Care Act, to insurance companies, fraternal benefit
2244 societies, hospital service corporations, medical service corporations

2245 and health care centers licensed to do business in the state.

2246 (d) No provision of the general statutes concerning a requirement of
2247 the Affordable Care Act shall be construed to supersede a provision of
2248 the general statutes that provides greater protection to an insured,
2249 except to the extent the latter prevents the application of a requirement
2250 of the Affordable Care Act.

2251 (e) The Insurance Commissioner may adopt regulations, in
2252 accordance with the provisions of chapter 54 of the general statutes, to
2253 implement the provisions of this section.

2254 Sec. 54. (NEW) (*Effective July 1, 2011*) As used in this section and
2255 sections 55 to 66, inclusive, of this act:

2256 (1) "Adverse determination" means:

2257 (A) The denial, reduction, termination or failure to provide or make
2258 payment, in whole or in part, for a benefit under the health carrier's
2259 health benefit plan requested by a covered person or a covered
2260 person's treating health care professional, based on a determination by
2261 a health carrier or its designee utilization review company:

2262 (i) That, based upon the information provided, (I) upon application
2263 of any utilization review technique, such benefit does not meet the
2264 health carrier's requirements for medical necessity, appropriateness,
2265 health care setting, level of care or effectiveness, or (II) is determined to
2266 be experimental or investigational;

2267 (ii) Of a covered person's eligibility to participate in the health
2268 carrier's health benefit plan; or

2269 (B) Any prospective review, concurrent review or retrospective
2270 review determination that denies, reduces or terminates or fails to
2271 provide or make payment, in whole or in part, for a benefit under the
2272 health carrier's health benefit plan requested by a covered person or a
2273 covered person's treating health care professional.

2274 "Adverse determination" includes a rescission of coverage
2275 determination for grievance purposes.

2276 (2) "Authorized representative" means:

2277 (A) A person to whom a covered person has given express written
2278 consent to represent the covered person for the purposes of this section
2279 and sections 55 to 66, inclusive, of this act;

2280 (B) A person authorized by law to provide substituted consent for a
2281 covered person;

2282 (C) A family member of the covered person or the covered person's
2283 treating health care professional when the covered person is unable to
2284 provide consent;

2285 (D) A health care professional when the covered person's health
2286 benefit plan requires that a request for a benefit under the plan be
2287 initiated by the health care professional; or

2288 (E) In the case of an urgent care request, a health care professional
2289 with knowledge of the covered person's medical condition.

2290 (3) "Best evidence" means evidence based on (A) randomized
2291 clinical trials, (B) if randomized clinical trials are not available, cohort
2292 studies or case-control studies, (C) if such trials and studies are not
2293 available, case-series, or (D) if such trials, studies and case-series are
2294 not available, expert opinion.

2295 (4) "Case-control study" means a retrospective evaluation of two
2296 groups of patients with different outcomes to determine which specific
2297 interventions the patients received.

2298 (5) "Case-series" means an evaluation of a series of patients with a
2299 particular outcome, without the use of a control group.

2300 (6) "Certification" means a determination by a health carrier or its
2301 designee utilization review company that a request for a benefit under

2302 the health carrier's health benefit plan has been reviewed and, based
2303 on the information provided, satisfies the health carrier's requirements
2304 for medical necessity, appropriateness, health care setting, level of care
2305 and effectiveness.

2306 (7) "Clinical peer" means a physician or other health care
2307 professional who holds a nonrestricted license in a state of the United
2308 States and in the same or similar specialty as typically manages the
2309 medical condition, procedure or treatment under review.

2310 (8) "Clinical review criteria" means the written screening
2311 procedures, decision abstracts, clinical protocols and practice
2312 guidelines used by the health carrier to determine the medical
2313 necessity and appropriateness of health care services.

2314 (9) "Cohort study" means a prospective evaluation of two groups of
2315 patients with only one group of patients receiving a specific
2316 intervention or specific interventions.

2317 (10) "Commissioner" means the Insurance Commissioner.

2318 (11) "Concurrent review" means utilization review conducted
2319 during a patient's stay or course of treatment in a facility, the office of a
2320 health care professional or other inpatient or outpatient health care
2321 setting, including home care.

2322 (12) "Covered benefits" or "benefits" means health care services to
2323 which a covered person is entitled under the terms of a health benefit
2324 plan.

2325 (13) "Covered person" means a policyholder, subscriber, enrollee or
2326 other individual participating in a health benefit plan.

2327 (14) "Emergency medical condition" means a medical condition
2328 manifesting itself by acute symptoms of sufficient severity, including
2329 severe pain, such that a prudent lay-person with an average
2330 knowledge of health and medicine, acting reasonably, would have
2331 believed that the absence of immediate medical attention would result

2332 in serious impairment to bodily functions or serious dysfunction of a
2333 bodily organ or part, or would place the person's health or, with
2334 respect to a pregnant woman, the health of the woman or her unborn
2335 child, in serious jeopardy.

2336 (15) "Emergency services" means, with respect to an emergency
2337 medical condition:

2338 (A) A medical screening examination that is within the capability of
2339 the emergency department of a hospital, including ancillary services
2340 routinely available to the emergency department to evaluate such
2341 emergency medical condition; and

2342 (B) Such further medical examination and treatment, to the extent
2343 they are within the capability of the staff and facilities available at a
2344 hospital, to stabilize a patient.

2345 (16) "Evidence-based standard" means the conscientious, explicit
2346 and judicious use of the current best evidence based on an overall
2347 systematic review of medical research when making determinations
2348 about the care of individual patients.

2349 (17) "Expert opinion" means a belief or an interpretation by
2350 specialists with experience in a specific area about the scientific
2351 evidence pertaining to a particular service, intervention or therapy.

2352 (18) "Facility" means an institution providing health care services or
2353 a health care setting. "Facility" includes a hospital and other licensed
2354 inpatient center, ambulatory surgical or treatment center, skilled
2355 nursing center, residential treatment center, diagnostic, laboratory and
2356 imaging center, and rehabilitation and other therapeutic health care
2357 setting.

2358 (19) "Final adverse determination" means an adverse determination
2359 (A) that has been upheld by the health carrier at the completion of its
2360 internal grievance process, or (B) for which the internal grievance
2361 process has been deemed exhausted.

2362 (20) "Grievance" means a written complaint or, if the complaint
2363 involves an urgent care request, an oral complaint, submitted by or on
2364 behalf of a covered person regarding:

2365 (A) The availability, delivery or quality of health care services,
2366 including a complaint regarding an adverse determination made
2367 pursuant to utilization review;

2368 (B) Claims payment, handling or reimbursement for health care
2369 services; or

2370 (C) Any matter pertaining to the contractual relationship between a
2371 covered person and a health carrier.

2372 (21) (A) "Health benefit plan" means an insurance policy or contract,
2373 certificate or agreement offered, delivered, issued for delivery,
2374 renewed, amended or continued in this state to provide, deliver,
2375 arrange for, pay for or reimburse any of the costs of health care
2376 services;

2377 (B) "Health benefit plan" does not include:

2378 (i) Coverage of the type specified in subdivisions (5) to (9), inclusive,
2379 (14) and (15) of section 38a-469 of the general statutes or any
2380 combination thereof;

2381 (ii) Coverage issued as a supplement to liability insurance;

2382 (iii) Liability insurance, including general liability insurance and
2383 automobile liability insurance;

2384 (iv) Workers' compensation insurance;

2385 (v) Automobile medical payment insurance;

2386 (vi) Credit insurance;

2387 (vii) Coverage for on-site medical clinics;

2388 (viii) Other insurance coverage similar to the coverages specified in
2389 subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are
2390 specified in regulations issued pursuant to the Health Insurance
2391 Portability and Accountability Act of 1996, P.L. 104-191, as amended
2392 from time to time, under which benefits for health care services are
2393 secondary or incidental to other insurance benefits;

2394 (ix) (I) Limited scope dental or vision benefits, (II) benefits for long-
2395 term care, nursing home care, home health care, community-based
2396 care or any combination thereof, or (III) other similar, limited benefits
2397 specified in regulations issued pursuant to the Health Insurance
2398 Portability and Accountability Act of 1996, P.L. 104-191, as amended
2399 from time to time, provided any benefits specified in subparagraphs
2400 (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided
2401 under a separate insurance policy, certificate or contract and are not
2402 otherwise an integral part of a health benefit plan; or

2403 (x) Coverage of the type specified in subdivisions (3) and (13) of
2404 section 38a-469 of the general statutes or other fixed indemnity
2405 insurance if (I) they are provided under a separate insurance policy,
2406 certificate or contract, (II) there is no coordination between the
2407 provision of the benefits and any exclusion of benefits under any
2408 group health plan maintained by the same plan sponsor, and (III) the
2409 benefits are paid with respect to an event without regard to whether
2410 benefits were also provided under any group health plan maintained
2411 by the same plan sponsor.

2412 (22) "Health care center" has the same meaning as provided in
2413 section 38a-175 of the general statutes.

2414 (23) "Health care professional" means a physician or other health
2415 care practitioner licensed, accredited or certified to perform specified
2416 health care services consistent with state law.

2417 (24) "Health care services" has the same meaning as provided in
2418 section 38a-478 of the general statutes, as amended by this act.

2419 (25) "Health carrier" means an entity subject to the insurance laws
2420 and regulations of this state or subject to the jurisdiction of the
2421 commissioner, that contracts or offers to contract to provide, deliver,
2422 arrange for, pay for or reimburse any of the costs of health care
2423 services, including a sickness and accident insurance company, a
2424 health care center, a managed care organization, a hospital service
2425 corporation, a medical service corporation or any other entity
2426 providing a plan of health insurance, health benefits or health care
2427 services.

2428 (26) "Health information" means information or data, whether oral
2429 or recorded in any form or medium, and personal facts or information
2430 about events or relationships that relate to (A) the past, present or
2431 future physical, mental, or behavioral health or condition of a covered
2432 person or a member of the covered person's family, (B) the provision of
2433 health care services to a covered person, or (C) payment for the
2434 provision of health care services to a covered person.

2435 (27) "Independent review organization" means an entity that
2436 conducts independent external reviews of adverse determinations and
2437 final adverse determinations. Such review entities include, but are not
2438 limited to, medical peer review organizations, independent utilization
2439 review companies, provided such organizations or companies are not
2440 related to or associated with any health carrier, and nationally
2441 recognized health experts or institutions approved by the Insurance
2442 Commissioner.

2443 (28) "Medical or scientific evidence" means evidence found in the
2444 following sources:

2445 (A) Peer-reviewed scientific studies published in or accepted for
2446 publication by medical journals that meet nationally recognized
2447 requirements for scientific manuscripts and that submit most of their
2448 published articles for review by experts who are not part of the
2449 editorial staff;

2450 (B) Peer-reviewed medical literature, including literature relating to

2451 therapies reviewed and approved by a qualified institutional review
2452 board, biomedical compendia and other medical literature that meet
2453 the criteria of the National Institutes of Health's Library of Medicine
2454 for indexing in Index Medicus (Medline) or Elsevier Science for
2455 indexing in Excerpta Medicus (EMBASE);

2456 (C) Medical journals recognized by the Secretary of the United
2457 States Department of Health and Human Services under Section
2458 1861(t)(2) of the Social Security Act;

2459 (D) The following standard reference compendia: (i) The American
2460 Hospital Formulary Service - Drug Information; (ii) Drug Facts and
2461 Comparisons; (iii) The American Dental Association's Accepted Dental
2462 Therapeutics; and (iv) The United States Pharmacopoeia - Drug
2463 Information;

2464 (E) Findings, studies or research conducted by or under the auspices
2465 of federal government agencies and nationally recognized federal
2466 research institutes, including: (i) The Agency for Healthcare Research
2467 and Quality; (ii) the National Institutes of Health; (iii) the National
2468 Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers
2469 for Medicare and Medicaid Services; (vi) the Food and Drug
2470 Administration; and (vii) any national board recognized by the
2471 National Institutes of Health for the purpose of evaluating the medical
2472 value of health care services; or

2473 (F) Any other findings, studies or research conducted by or under
2474 the auspices of a source comparable to those listed in subparagraphs
2475 (E)(i) to (E)(v), inclusive, of this subdivision.

2476 (29) "Medical necessity" has the same meaning as provided in
2477 sections 38a-482a and 38a-513c of the general statutes.

2478 (30) "Participating provider" means a health care professional who,
2479 under a contract with the health carrier, its contractor or subcontractor,
2480 has agreed to provide health care services to covered persons, with an
2481 expectation of receiving payment or reimbursement directly or

2482 indirectly from the health carrier, other than coinsurance, copayments
2483 or deductibles.

2484 (31) "Person" has the same meaning as provided in section 38a-1 of
2485 the general statutes.

2486 (32) "Prospective review" means utilization review conducted prior
2487 to an admission or the provision of a health care service or a course of
2488 treatment, in accordance with a health carrier's requirement that such
2489 service or treatment be approved, in whole or in part, prior to such
2490 service's or treatment's provision.

2491 (33) "Protected health information" means health information (A)
2492 that identifies an individual who is the subject of the information, or
2493 (B) for which there is a reasonable basis to believe that such
2494 information could be used to identify such individual.

2495 (34) "Randomized clinical trial" means a controlled, prospective
2496 study of patients that have been randomized into an experimental
2497 group and a control group at the beginning of the study, with only the
2498 experimental group of patients receiving a specific intervention, and
2499 that includes study of the groups for variables and anticipated
2500 outcomes over time.

2501 (35) "Rescission" means a cancellation or discontinuance of coverage
2502 under a health benefit plan that has a retroactive effect. "Rescission"
2503 does not include a cancellation or discontinuance of coverage under a
2504 health benefit plan if (A) such cancellation or discontinuance has a
2505 prospective effect only, or (B) such cancellation or discontinuance is
2506 effective retroactively to the extent it is attributable to the covered
2507 person's failure to timely pay required premiums or contributions
2508 towards the cost of such coverage.

2509 (36) "Retrospective review" means any review of a request for a
2510 benefit that is not a prospective review or concurrent review.
2511 "Retrospective review" does not include a review of a request that is
2512 limited to the veracity of documentation or the accuracy of coding.

2513 (37) "Stabilize" means, with respect to an emergency medical
2514 condition, that (A) no material deterioration of such condition is likely,
2515 within reasonable medical probability, to result from or occur during
2516 the transfer of the individual from a facility, or (B) with respect to a
2517 pregnant woman, the woman has delivered, including the placenta.

2518 (38) "Urgent care request" means a request for a health care service
2519 or course of treatment for which the time period for making a non-
2520 urgent care request determination (A) could seriously jeopardize the
2521 life or health of the covered person or the ability of the covered person
2522 to regain maximum function, or (B) in the opinion of a health care
2523 professional with knowledge of the covered person's medical
2524 condition, would subject the covered person to severe pain that cannot
2525 be adequately managed without the health care service or treatment
2526 being requested.

2527 (39) "Utilization review" means the use of a set of formal techniques
2528 designed to monitor the use of, or evaluate the medical necessity,
2529 appropriateness, efficacy or efficiency of, health care services, health
2530 care procedures or health care settings. Such techniques may include
2531 the monitoring of or evaluation of (A) health care services performed
2532 or provided in an outpatient setting, (B) the formal process for
2533 determining, prior to discharge from a facility, the coordination and
2534 management of the care that a patient receives following discharge
2535 from a facility, (C) opportunities or requirements to obtain a clinical
2536 evaluation by a health care professional other than the one originally
2537 making a recommendation for a proposed health care service, (D)
2538 coordinated sets of activities conducted for individual patient
2539 management of serious, complicated, protracted or other health
2540 conditions, or (E) prospective review, concurrent review, retrospective
2541 review or certification.

2542 (40) "Utilization review company" means an entity that conducts
2543 utilization review.

2544 Sec. 55. (NEW) (*Effective July 1, 2011*) (a) Sections 54 to 66, inclusive,

2545 of this act shall apply to (1) any health carrier offering a health benefit
2546 plan and that provides or performs utilization review including
2547 prospective, concurrent or retrospective review benefit determinations,
2548 and (2) any utilization review company or designee of a health carrier
2549 that performs utilization review on the health carrier's behalf,
2550 including prospective, concurrent or retrospective review benefit
2551 determinations.

2552 (b) Each health carrier shall be responsible for monitoring all
2553 utilization review program activities carried out by or on behalf of
2554 such health carrier. Such health carrier shall comply with the
2555 provisions of sections 54 to 66, inclusive, of this act and any regulations
2556 adopted thereunder, and shall be responsible for ensuring that any
2557 utilization review company or other entity such health carrier contracts
2558 with to perform utilization review complies with said sections and
2559 regulations. Each health carrier shall ensure that appropriate personnel
2560 have operational responsibility for the activities of the health carrier's
2561 utilization review program.

2562 (c) (1) A health carrier that requires utilization review of a benefit
2563 request under a health benefit plan shall implement a utilization
2564 review program and develop a written document that describes all
2565 utilization review activities and procedures, whether or not delegated,
2566 for (A) the filing of benefit requests, (B) the notification to covered
2567 persons of utilization review and benefit determinations, and (C) the
2568 review of adverse determinations and grievances in accordance with
2569 sections 58 and 59 of this act.

2570 (2) Such document shall describe the following:

2571 (A) Procedures to evaluate the medical necessity, appropriateness,
2572 health care setting, level of care or effectiveness of health care services;

2573 (B) Data sources and clinical review criteria used in making
2574 determinations;

2575 (C) Procedures to ensure consistent application of clinical review

- 2576 criteria and compatible determinations;
- 2577 (D) Data collection processes and analytical methods used to assess
2578 utilization of health care services;
- 2579 (E) Provisions to ensure the confidentiality of clinical, proprietary
2580 and protected health information;
- 2581 (F) The health carrier's organizational mechanism, such as a
2582 utilization review committee or quality assurance or other committee,
2583 that periodically assesses the health carrier's utilization review
2584 program and reports to the health carrier's governing body; and
- 2585 (G) The health carrier's staff position that is responsible for the day-
2586 to-day management of the utilization review program.
- 2587 (d) Each health carrier shall:
- 2588 (1) Include in the insurance policy, certificate of coverage or
2589 handbook provided to covered persons a clear and comprehensive
2590 description of:
- 2591 (A) Its utilization review and benefit determination procedures;
- 2592 (B) Its grievance procedures, including the grievance procedures for
2593 requesting a review of an adverse determination;
- 2594 (C) A description of the external review procedures set forth in
2595 section 60 of this act, in a format prescribed by the commissioner and
2596 including a statement that discloses that:
- 2597 (i) A covered person may file a request for an external review of an
2598 adverse determination or a final adverse determination with the
2599 commissioner and that such review is available when the adverse
2600 determination or the final adverse determination involves an issue of
2601 medical necessity, appropriateness, health care setting, level of care or
2602 effectiveness. Such disclosure shall include the contact information of
2603 the commissioner; and

2604 (ii) When filing a request for an external review of an adverse
2605 determination or a final adverse determination, the covered person
2606 shall be required to authorize the release of any medical records that
2607 may be required to be reviewed for the purpose of making a decision
2608 on such request;

2609 (D) A statement of the rights and responsibilities of covered persons
2610 with respect to each of the procedures under subparagraphs (A) to (C),
2611 inclusive, of this subdivision. Such statement shall include a disclosure
2612 that a covered person has the right to contact the commissioner's office
2613 or the Office of Healthcare Advocate at any time for assistance and
2614 shall include the contact information for said offices;

2615 (2) Inform its covered persons, at the time of initial enrollment and
2616 at least annually thereafter, of its grievance procedures. This
2617 requirement may be fulfilled by including such procedures in an
2618 enrollment agreement or update to such agreement;

2619 (3) Inform a covered person and the covered person's health care
2620 professional of the health carrier's grievance procedures whenever the
2621 health carrier denies certification of a benefit requested by a covered
2622 person's health care professional;

2623 (4) Include in materials intended for prospective covered persons a
2624 summary of its utilization review and benefit determination
2625 procedures;

2626 (5) Print on its membership or identification cards a toll-free
2627 telephone number for utilization review and benefit determinations;

2628 (6) Maintain records of all benefit requests, claims and notices
2629 associated with utilization review and benefit determinations made in
2630 accordance with section 57 of this act for not less than six years after
2631 such requests, claims and notices were made. Each health carrier shall
2632 make such records available for examination by the commissioner and
2633 appropriate federal oversight agencies upon request; and

2634 (7) Maintain records in accordance with section 61 of this act of all
2635 grievances received. Each health carrier shall make such records
2636 available for examination by covered persons, to the extent such
2637 records are permitted to be disclosed by law, the commissioner and
2638 appropriate federal oversight agencies upon request.

2639 (e) (1) On or before March first annually, each health carrier shall
2640 file with the commissioner:

2641 (A) A summary report of its utilization review program activities in
2642 the calendar year immediately preceding; and

2643 (B) A report that includes for each type of health benefit plan
2644 offered by the health carrier:

2645 (i) A certificate of compliance certifying that the utilization review
2646 program of the health carrier or its designee complies with all
2647 applicable state and federal laws concerning confidentiality and
2648 reporting requirements;

2649 (ii) The number of covered lives;

2650 (iii) The total number of grievances received;

2651 (iv) The number of grievances resolved at each level, if applicable,
2652 and their resolution;

2653 (v) The number of grievances appealed to the commissioner of
2654 which the health carrier has been informed;

2655 (vi) The number of grievances referred to alternative dispute
2656 resolution procedures or resulting in litigation; and

2657 (vii) A synopsis of actions being taken to correct any problems
2658 identified.

2659 (2) The commissioner shall adopt regulations, in accordance with
2660 chapter 54, to establish the form and content of the reports specified in
2661 subdivision (1) of this subsection.

2662 Sec. 56. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
2663 contract with (A) health care professionals to administer such health
2664 carrier's utilization review program and oversee utilization review
2665 determinations, and (B) with clinical peers to evaluate the clinical
2666 appropriateness of an adverse determination.

2667 (2) Each utilization review program shall use documented clinical
2668 review criteria that are based on sound clinical evidence and are
2669 evaluated periodically by the health carrier's organizational
2670 mechanism specified in subparagraph (F) of subdivision (2) of
2671 subsection (c) of section 55 of this act to assure such program's ongoing
2672 effectiveness. A health carrier may develop its own clinical review
2673 criteria or it may purchase or license clinical review criteria from
2674 qualified vendors approved by the commissioner. Each health carrier
2675 shall make its clinical review criteria available upon request to
2676 authorized government agencies.

2677 (b) Each health carrier shall:

2678 (1) Have procedures in place to ensure that the health care
2679 professionals administering such health carrier's utilization review
2680 program are applying the clinical review criteria consistently in
2681 utilization review determinations;

2682 (2) Have data systems sufficient to support utilization review
2683 program activities and to generate management reports to enable the
2684 health carrier to monitor and manage health care services effectively;

2685 (3) Provide covered persons and participating providers with access
2686 to its utilization review staff through a toll-free telephone number or
2687 any other free calling option or by electronic means;

2688 (4) Coordinate the utilization review program with other medical
2689 management activity conducted by the health carrier, such as quality
2690 assurance, credentialing, contracting with health care professionals,
2691 data reporting, grievance procedures, processes for assessing member
2692 satisfaction and risk management; and

2693 (5) Routinely assess the effectiveness and efficiency of its utilization
2694 review program.

2695 (c) If a health carrier delegates any utilization review activities to a
2696 utilization review company, the health carrier shall maintain adequate
2697 oversight, which shall include (1) a written description of the
2698 utilization review company's activities and responsibilities, including
2699 such company's reporting requirements, (2) evidence of the health
2700 carrier's formal approval of the utilization review company program,
2701 and (3) a process by which the health carrier shall evaluate the
2702 utilization review company's performance.

2703 (d) When conducting utilization review, the health carrier shall (1)
2704 collect only the information necessary, including pertinent clinical
2705 information, to make the utilization review or benefit determination,
2706 and (2) ensure that such review is conducted in a manner to ensure the
2707 independence and impartiality of the individual or individuals
2708 involved in making the utilization review or benefit determination. No
2709 health carrier shall make decisions regarding the hiring, compensation,
2710 termination, promotion or other similar matters of such individual or
2711 individuals based on the likelihood that the individual or individuals
2712 will support the denial of benefits.

2713 Sec. 57. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
2714 maintain written procedures for (A) utilization review and benefit
2715 determinations, (B) expedited utilization review and benefit
2716 determinations with respect to prospective urgent care requests and
2717 concurrent review urgent care requests, and (C) notifying covered
2718 persons or covered persons' authorized representatives of such review
2719 and benefit determinations. Each health carrier shall make such review
2720 and benefit determinations within the specified time periods under
2721 this section.

2722 (2) In determining whether a benefit request shall be considered an
2723 urgent care request, an individual acting on behalf of a health carrier
2724 shall apply the judgment of a prudent layperson who possesses an

2725 average knowledge of health and medicine, except that any benefit
2726 request determined to be an urgent care request by a health care
2727 professional with knowledge of the covered person's medical
2728 condition shall be deemed an urgent care request.

2729 (b) With respect to a nonurgent care request:

2730 (1) For a prospective or concurrent review request, a health carrier
2731 shall make a determination within a reasonable period of time
2732 appropriate to the covered person's medical condition, but not later
2733 than fifteen calendar days after the date the health carrier receives such
2734 request, and shall notify the covered person and, if applicable, the
2735 covered person's authorized representative of such determination,
2736 whether or not the carrier certifies the provision of the benefit.

2737 (2) For a retrospective review request, a health carrier shall make a
2738 determination within a reasonable period of time, but not later than
2739 thirty calendar days after the date the health carrier receives such
2740 request.

2741 (3) The time periods specified in subdivisions (1) and (2) of this
2742 subsection may be extended once by the health carrier for up to fifteen
2743 calendar days, provided the health carrier:

2744 (A) Determines that an extension is necessary due to circumstances
2745 beyond the health carrier's control; and

2746 (B) Notifies the covered person and, if applicable, the covered
2747 person's authorized representative prior to the expiration of the initial
2748 time period, of the circumstances requiring the extension of time and
2749 the date by which the health carrier expects to make a determination.

2750 (4) (A) If the extension pursuant to subdivision (3) of this subsection
2751 is necessary due to the failure of the covered person or the covered
2752 person's authorized representative to provide information necessary to
2753 make a determination on the request, the health carrier shall:

2754 (i) Specifically describe in the notice of extension the required

2755 information necessary to complete the request; and

2756 (ii) Provide the covered person and, if applicable, the covered
2757 person's authorized representative with not less than forty-five
2758 calendar days after the date of receipt of the notice to provide the
2759 specified information.

2760 (B) If the covered person or the covered person's authorized
2761 representative fails to submit the specified information before the end
2762 of the period of the extension, the health carrier may deny certification
2763 of the benefit requested.

2764 (c) With respect to an urgent care request:

2765 (1) Unless the covered person or the covered person's authorized
2766 representative has failed to provide information necessary for the
2767 health carrier to make a determination, the health carrier shall make a
2768 determination as soon as possible, taking into account the covered
2769 person's medical condition, but not later than seventy-two hours after
2770 the health carrier receives such request, provided, if the urgent care
2771 request is a concurrent review request to extend a course of treatment
2772 beyond the initial period of time or the number of treatments, such
2773 request is made at least twenty-four hours prior to the expiration of the
2774 prescribed period of time or number of treatments;

2775 (2) (A) If the covered person or the covered person's authorized
2776 representative has failed to provide information necessary for the
2777 health carrier to make a determination, the health carrier shall notify
2778 the covered person or the covered person's representative, as
2779 applicable, as soon as possible, but not later than twenty-four hours
2780 after the health carrier receives such request.

2781 (B) The health carrier shall provide the covered person or the
2782 covered person's authorized representative, as applicable, a reasonable
2783 period of time to submit the specified information, taking into account
2784 the covered person's medical condition, but not less than forty-eight
2785 hours after notifying the covered person or the covered person's

2786 authorized representative, as applicable.

2787 (3) The health carrier shall notify the covered person and, if
2788 applicable, the covered person's authorized representative of its
2789 determination as soon as possible, but not later than forty-eight hours
2790 after the earlier of (i) the date on which the covered person and the
2791 covered person's authorized representative, as applicable, provides the
2792 specified information to the health carrier, or (ii) the date on which the
2793 specified information was to have been submitted.

2794 (d) (1) Whenever a health carrier receives a review request from a
2795 covered person or a covered person's authorized representative that
2796 fails to meet the health carrier's filing procedures, the health carrier
2797 shall notify the covered person and, if applicable, the covered person's
2798 authorized representative of such failure not later than five calendar
2799 days after the health carrier receives such request, except that for an
2800 urgent care request, the health carrier shall notify the covered person
2801 and, if applicable, the covered person's authorized representative of
2802 such failure not later than twenty-four hours after the health carrier
2803 receives such request.

2804 (2) If the health carrier provides such notice orally, the health carrier
2805 shall provide confirmation in writing to the covered person and the
2806 covered person's health care professional of record not later than five
2807 calendar days after providing the oral notice.

2808 (e) Each health carrier shall provide promptly to a covered person
2809 and, if applicable, the covered person's authorized representative a
2810 notice of an adverse determination. Such notice may be provided in
2811 writing or by electronic means and shall set forth, in a manner
2812 calculated to be understood by the covered person or the covered
2813 person's authorized representative:

2814 (1) Information sufficient to identify the benefit request or claim
2815 involved, including the date of service, if applicable, the health care
2816 professional and the claim amount;

2817 (2) The specific reason or reasons for the adverse determination and
2818 a description of the health carrier's standard, if any, that was used in
2819 reaching the denial;

2820 (3) Reference to the specific health benefit plan provisions on which
2821 the determination is based;

2822 (4) A description of any additional material or information
2823 necessary for the covered person to perfect the benefit request or claim,
2824 including an explanation of why the material or information is
2825 necessary to perfect the request or claim;

2826 (5) A description of the health carrier's internal grievance process
2827 that includes (A) the health carrier's expedited review procedures, (B)
2828 any time limits applicable to such process or procedures, (C) the
2829 contact information for the organizational unit designated to
2830 coordinate the review on behalf of the health carrier, and (D) a
2831 statement that the covered person or, if applicable, the covered
2832 person's authorized representative is entitled, pursuant to the
2833 requirements of the health carrier's internal grievance process, to (i)
2834 submit written comments, documents, records and other material
2835 relating to the covered person's benefit request for consideration by the
2836 individual or individuals conducting the review, and (ii) receive from
2837 the health carrier, free of charge upon request, reasonable access to and
2838 copies of all documents, records and other information relevant to the
2839 covered person's benefit request;

2840 (6) If the adverse determination is based on a health carrier's
2841 internal rule, guideline, protocol or other similar criterion, (A) the
2842 specific rule, guideline, protocol or other similar criterion, or (B) a
2843 statement that a specific rule, guideline, protocol or other similar
2844 criterion of the health carrier was relied upon to make the adverse
2845 determination and that a copy of such rule, guideline, protocol or other
2846 similar criterion will be provided to the covered person free of charge
2847 upon request, and instructions for requesting such copy;

2848 (7) If the adverse determination is based on medical necessity or an

2849 experimental or investigational treatment or similar exclusion or limit,
2850 the written statement of the scientific or clinical rationale for the
2851 adverse determination and (A) an explanation of the scientific or
2852 clinical rationale used to make the determination that applies the terms
2853 of the health benefit plan to the covered person's medical
2854 circumstances, or (B) a statement that an explanation will be provided
2855 to the covered person free of charge upon request, and instructions for
2856 requesting a copy of such explanation; and

2857 (8) A statement explaining the right of the covered person to contact
2858 the commissioner's office or the Office of the Healthcare Advocate at
2859 any time for assistance or, upon completion of the health carrier's
2860 internal grievance process, to file a civil suit in a court of competent
2861 jurisdiction. Such statement shall include the contact information for
2862 said offices.

2863 (f) If the adverse determination is a rescission, the health carrier
2864 shall include with the advance notice of the application for rescission
2865 required to be sent to the covered person, a written statement that
2866 includes:

2867 (1) Clear identification of the alleged fraudulent act, practice or
2868 omission or the intentional misrepresentation of material fact;

2869 (2) An explanation as to why the act, practice or omission was
2870 fraudulent or was an intentional misrepresentation of a material fact;

2871 (3) A disclosure that the covered person or the covered person's
2872 authorized representative may file immediately, without waiting for
2873 the date such advance notice of the proposed rescission ends, a
2874 grievance with the health carrier to request a review of the adverse
2875 determination to rescind coverage, pursuant to sections 58 and 59 of
2876 this act;

2877 (4) A description of the health carrier's grievance procedures
2878 established under sections 58 and 59 of this act, including any time
2879 limits applicable to those procedures; and

2880 (5) The date such advance notice of the proposed rescission ends
2881 and the date back to which the coverage will be retroactively
2882 rescinded.

2883 (g) (1) Whenever a health carrier fails to strictly adhere to the
2884 requirements of this section with respect to making utilization review
2885 and benefit determinations of a benefit request or claim, the covered
2886 person shall be deemed to have exhausted the internal grievance
2887 process of such health carrier and may file a request for an external
2888 review in accordance with the provisions of section 60 of this act,
2889 regardless of whether the health carrier asserts it substantially
2890 complied with the requirements of this section or that any error it
2891 committed was de minimis.

2892 (2) A covered person who has exhausted the internal grievance
2893 process of a health carrier may, in addition to filing a request for an
2894 external review, pursue any available remedies under state or federal
2895 law on the basis that the health carrier failed to provide a reasonable
2896 internal grievance process that would yield a decision on the merits of
2897 the claim.

2898 Sec. 58. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
2899 establish and maintain written procedures for (A) the review of
2900 grievances of adverse determinations that were based, in whole or in
2901 part, on medical necessity, (B) the expedited review of grievances of
2902 adverse determinations of urgent care requests, including concurrent
2903 review urgent care requests involving an admission, availability of
2904 care, continued stay or health care service for a covered person who
2905 has received emergency services but has not been discharged from a
2906 facility, and (C) notifying covered persons or covered persons'
2907 authorized representatives of such adverse determinations.

2908 (2) Each health carrier shall file with the commissioner a copy of
2909 such procedures, including all forms used to process requests, and any
2910 subsequent material modifications to such procedures.

2911 (3) In addition to a copy of such procedures, each health carrier shall

2912 file annually with the commissioner, as part of its annual report
2913 required under subsection (e) of section 55 of this act, a certificate of
2914 compliance stating that the health carrier has established and
2915 maintains grievance procedures for each of its health benefit plans that
2916 are fully compliant with the provisions of sections 54 to 66, inclusive,
2917 of this act.

2918 (b) (1) A covered person or a covered person's authorized
2919 representative may file a grievance of an adverse determination that
2920 was based, in whole or in part, on medical necessity with the health
2921 carrier not later than one hundred eighty calendar days after the
2922 covered person or the covered person's authorized representative, as
2923 applicable, receives the notice of an adverse determination.

2924 (2) For prospective or concurrent urgent care requests, a covered
2925 person or a covered person's authorized representative may make a
2926 request for an expedited review orally or in writing.

2927 (c) (1) (A) When conducting a review of an adverse determination
2928 under this section, the health carrier shall ensure that such review is
2929 conducted in a manner to ensure the independence and impartiality of
2930 the individual or individuals involved in making the review decision.

2931 (B) If the adverse determination involves utilization review, the
2932 health carrier shall designate an appropriate clinical peer or peers to
2933 review such adverse determination. Such clinical peer or peers shall
2934 not have been involved in the initial adverse determination.

2935 (C) The individual or individuals conducting a review under this
2936 section shall take into consideration all comments, documents, records
2937 and other information relevant to the covered person's benefit request
2938 that is the subject of the adverse determination under review, that are
2939 submitted by the covered person or the covered person's authorized
2940 representative, regardless of whether such information was submitted
2941 or considered in making the initial adverse determination.

2942 (D) Prior to issuing a decision, the health carrier shall provide free

2943 of charge to the covered person or the covered person's authorized
2944 representative, as applicable, any new or additional evidence relied
2945 upon and any new or additional scientific or clinical rationale used by
2946 the health carrier in connection with the grievance. Such evidence and
2947 rationale shall be provided sufficiently in advance of the date the
2948 health carrier is required to issue a decision to permit the covered
2949 person or the covered person's authorized representative, as
2950 applicable, a reasonable opportunity to respond prior to such date.

2951 (2) If the review under subdivision (1) of this subsection is an
2952 expedited review, all necessary information, including the health
2953 carrier's decision, shall be transmitted between the health carrier and
2954 the covered person or the covered person's authorized representative,
2955 as applicable, by telephone, facsimile, electronic means or any other
2956 expeditious method available.

2957 (3) If the review under subdivision (1) of this subsection is an
2958 expedited review of a grievance involving an adverse determination of
2959 a concurrent review urgent care request, the treatment shall be
2960 continued without liability to the covered person until the covered
2961 person has been notified of the review decision.

2962 (d) (1) The health carrier shall notify the covered person and, if
2963 applicable, the covered person's authorized representative, in writing
2964 or by electronic means, of its decision within a reasonable period of
2965 time appropriate to the covered person's medical condition, but not
2966 later than:

2967 (A) For prospective review and concurrent review requests, thirty
2968 calendar days after the health carrier receives the grievance;

2969 (B) For retrospective review requests, sixty calendar days after the
2970 health carrier receives the grievance; and

2971 (C) For expedited review requests, seventy-two hours after the
2972 health carrier receives the grievance.

2973 (2) The time periods set forth in subdivision (1) of this subsection
2974 shall apply regardless of whether all of the information necessary to
2975 make a decision accompanies the filing.

2976 (e) The notice required under subsection (d) of this section shall set
2977 forth, in a manner calculated to be understood by the covered person
2978 or the covered person's authorized representative:

2979 (1) The titles and qualifying credentials of the individual or
2980 individuals participating in the review process;

2981 (2) Information sufficient to identify the claim involved with respect
2982 to the grievance, including the date of service, if applicable, the health
2983 care professional and the claim amount;

2984 (3) A statement of such individual's or individuals' understanding
2985 of the covered person's grievance;

2986 (4) The individual's or individuals' decision in clear terms and the
2987 health benefit plan contract basis or scientific or clinical rationale for
2988 such decision in sufficient detail for the covered person to respond
2989 further to the health carrier's position;

2990 (5) Reference to the evidence or documentation used as the basis for
2991 the decision;

2992 (6) For a decision that upholds the adverse determination:

2993 (A) The specific reason or reasons for the final adverse
2994 determination, including the denial code and its corresponding
2995 meaning, as well as a description of the health carrier's standard, if
2996 any, that was used in reaching the denial;

2997 (B) Reference to the specific health benefit plan provisions on which
2998 the decision is based;

2999 (C) A statement that the covered person may receive from the health
3000 carrier, free of charge and upon request, reasonable access to and

3001 copies of, all documents, records and other information relevant to the
3002 adverse determination under review;

3003 (D) If the final adverse determination is based on a health carrier's
3004 internal rule, guideline, protocol or other similar criterion, (i) the
3005 specific rule, guideline, protocol or other similar criterion, or (ii) a
3006 statement that a specific rule, guideline, protocol or other similar
3007 criterion of the health carrier was relied upon to make the final adverse
3008 determination and that a copy of such rule, guideline, protocol or other
3009 similar criterion will be provided to the covered person free of charge
3010 upon request and instructions for requesting such copy;

3011 (E) If the final adverse determination is based on medical necessity
3012 or an experimental or investigational treatment or similar exclusion or
3013 limit, the written statement of the scientific or clinical rationale for the
3014 final adverse determination and (i) an explanation of the scientific or
3015 clinical rationale used to make the determination that applies the terms
3016 of the health benefit plan to the covered person's medical
3017 circumstances, or (ii) a statement that an explanation will be provided
3018 to the covered person free of charge upon request and instructions for
3019 requesting a copy of such explanation;

3020 (F) A statement describing the procedures for obtaining an external
3021 review of the final adverse determination;

3022 (7) If applicable, the following statement: "You and your plan may
3023 have other voluntary alternative dispute resolution options such as
3024 mediation. One way to find out what may be available is to contact
3025 your state Insurance Commissioner."; and

3026 (8) A statement disclosing the covered person's right to contact the
3027 commissioner's office or the Office of the Healthcare Advocate at any
3028 time. Such disclosure shall include the contact information for said
3029 offices.

3030 (f) (1) Whenever a health carrier fails to strictly adhere to the
3031 requirements of this section with respect to receiving and resolving

3032 grievances involving an adverse determination, the covered person
3033 shall be deemed to have exhausted the internal grievance process of
3034 such health carrier and may file a request for an external review,
3035 regardless of whether the health carrier asserts that it substantially
3036 complied with the requirements of this section, or that any error it
3037 committed was de minimis.

3038 (2) A covered person who has exhausted the internal grievance
3039 process of a health carrier may, in addition to filing a request for an
3040 external review, pursue any available remedies under state or federal
3041 law on the basis that the health carrier failed to provide a reasonable
3042 internal grievance process that would yield a decision on the merits of
3043 the claim.

3044 Sec. 59. (NEW) (*Effective July 1, 2011*) (a) Each health carrier shall
3045 establish and maintain written procedures (1) for the review of
3046 grievances of adverse determinations that were not based on medical
3047 necessity, and (2) notifying covered persons or covered persons'
3048 authorized representatives of such adverse determinations.

3049 (b) (1) A covered person or the covered person's authorized
3050 representative may file a grievance of an adverse determination that
3051 was not based on medical necessity with the health carrier not later
3052 than one hundred eighty calendar days after the covered person or the
3053 covered person's representative, as applicable, receives the notice of an
3054 adverse determination.

3055 (2) The health carrier shall notify the covered person and, if
3056 applicable, the covered person's authorized representative not later
3057 than three business days after the health carrier receives a grievance
3058 that the covered person or the covered person's authorized
3059 representative, as applicable, is entitled to submit written material to
3060 the health carrier to be considered when conducting a review of the
3061 grievance.

3062 (3) (A) Upon receipt of a grievance, a health carrier shall designate
3063 an individual or individuals to conduct a review of the grievance.

3064 (B) The health carrier shall not designate the same individual or
3065 individuals who denied the claim or handled the matter that is the
3066 subject of the grievance to conduct the review of the grievance.

3067 (C) The health carrier shall provide the covered person and, if
3068 applicable, the covered person's authorized representative with the
3069 name, address and telephone number of the individual or the
3070 organizational unit designated to coordinate the review on behalf of
3071 the health carrier.

3072 (c) (1) The health carrier shall notify the covered person and, if
3073 applicable, the covered person's authorized representative in writing,
3074 of its decision not later than twenty business days after the health
3075 carrier received the grievance.

3076 (2) If the health carrier is unable to comply with the time period
3077 specified in subdivision (1) of this subsection due to circumstances
3078 beyond the health carrier's control, the time period may be extended
3079 by the health carrier for up to ten business days, provided that on or
3080 before the twentieth business day after the health carrier received the
3081 grievance, the health carrier provides written notice to the covered
3082 person and, if applicable, the covered person's authorized
3083 representative of the extension and the reasons for the delay.

3084 (d) The written decision issued pursuant to subsection (c) of this
3085 section shall contain:

3086 (1) The titles and qualifying credentials of the individual or
3087 individuals participating in the review process;

3088 (2) A statement of such individual's or individuals' understanding
3089 of the covered person's grievance;

3090 (3) The individual's or individuals' decision in clear terms and the
3091 health benefit plan contract basis for such decision in sufficient detail
3092 for the covered person to respond further to the health carrier's
3093 position; and

3094 (4) Reference to the evidence or documentation used as the basis for
3095 the decision.

3096 Sec. 60. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or a
3097 covered person's authorized representative may file a request for an
3098 external review or an expedited external review of an adverse
3099 determination or a final adverse determination in accordance with the
3100 provisions of this section. All requests for external review or expedited
3101 external review shall be made in writing to the commissioner. The
3102 commissioner may prescribe the form and content of such requests.

3103 (2) (A) All requests for external review or expedited external review
3104 shall be accompanied by a filing fee of twenty-five dollars, except that
3105 no covered person or covered person's authorized representative shall
3106 pay more than seventy-five dollars in a calendar year for such covered
3107 person. Any filing fee paid by a covered person's authorized
3108 representative shall be deemed to have been paid by the covered
3109 person. If the commissioner finds that the covered person is indigent
3110 or unable to pay the filing fee, the commissioner shall waive such fee.
3111 Any such fees shall be deposited in the Insurance Fund established
3112 under section 38a-52a of the general statutes.

3113 (B) The commissioner shall refund any paid filing fee to the covered
3114 person or the covered person's authorized representative, as
3115 applicable, or the health care professional if the adverse determination
3116 or the final adverse determination that is the subject of the external
3117 review request or expedited external review request is reversed or
3118 revised.

3119 (3) The health carrier that issued the adverse determination or the
3120 final adverse determination that is the subject of the external review
3121 request or the expedited external review request shall pay the
3122 independent review organization for the cost of conducting the review.

3123 (4) An external review decision, whether such review is a standard
3124 external review or an expedited external review, shall be binding on
3125 the health carrier or a self-insured governmental plan and the covered

3126 person, except to the extent such health carrier or covered person has
3127 other remedies available under federal or state law. A covered person
3128 or a covered person's authorized representative shall not file a
3129 subsequent request for an external review or an expedited external
3130 review that involves the same adverse determination or final adverse
3131 determination for which the covered person or the covered person's
3132 authorized representative already received an external review decision
3133 or an expedited external review decision.

3134 (5) Each health carrier shall maintain written records of external
3135 reviews as set forth in section 61 of this act.

3136 (6) Each independent review organization shall maintain written
3137 records as set forth in subsection (e) of section 66 of this act.

3138 (b) (1) Except as otherwise provided under subdivision (2) of this
3139 subsection or subsection (d) of this section, a covered person or a
3140 covered person's authorized representative shall not file a request for
3141 an external review or an expedited external review until the covered
3142 person or the covered person's authorized representative has
3143 exhausted the health carrier's internal grievance process.

3144 (2) A health carrier may waive its internal grievance process and the
3145 requirement for a covered person to exhaust such process prior to
3146 filing a request for an external review or an expedited external review.

3147 (c) (1) At the same time a health carrier sends to a covered person or
3148 a covered person's authorized representative a written notice of an
3149 adverse determination or a final adverse determination issued by the
3150 health carrier, the health carrier shall include a written disclosure to
3151 the covered person and, if applicable, the covered person's authorized
3152 representative of the covered person's right to request an external
3153 review.

3154 (2) The written notice shall include:

3155 (A) The following statement or a statement in substantially similar

3156 language: "We have denied your request for benefit approval for a
3157 health care service or course of treatment. You may have the right to
3158 have our decision reviewed by health care professionals who have no
3159 association with us by submitting a request for external review to the
3160 office of the Insurance Commissioner, if our decision involved making
3161 a judgment as to the medical necessity, appropriateness, health care
3162 setting, level of care or effectiveness of the health care service or
3163 treatment you requested.";

3164 (B) For a notice related to an adverse determination, a statement
3165 informing the covered person that:

3166 (i) If the covered person has a medical condition for which the time
3167 period for completion of an expedited internal review of a grievance
3168 involving an adverse determination would seriously jeopardize the life
3169 or health of the covered person or would jeopardize the covered
3170 person's ability to regain maximum function, the covered person or the
3171 covered person's authorized representative may (I) file a request for an
3172 expedited external review, or (II) file a request for an expedited
3173 external review if the adverse determination involves a denial of
3174 coverage based on a determination that the recommended or
3175 requested health care service or treatment is experimental or
3176 investigational and the covered person's treating health care
3177 professional certifies in writing that such recommended or requested
3178 health care service or treatment would be significantly less effective if
3179 not promptly initiated; and

3180 (ii) Such request for expedited external review may be filed at the
3181 same time the covered person or the covered person's authorized
3182 representative files a request for an expedited internal review of a
3183 grievance involving an adverse determination, except that the
3184 independent review organization assigned to conduct the expedited
3185 external review shall determine whether the covered person shall be
3186 required to complete the expedited internal review of the grievance
3187 prior to conducting the expedited external review;

3188 (C) For a notice related to a final adverse determination, a statement
3189 informing the covered person that:

3190 (i) If the covered person has a medical condition for which the time
3191 period for completion of an external review would seriously
3192 jeopardize the life or health of the covered person or would jeopardize
3193 the covered person's ability to regain maximum function, the covered
3194 person or the covered person's authorized representative may file a
3195 request for an expedited external review; or

3196 (ii) If the final adverse determination concerns (I) an admission,
3197 availability of care, continued stay or health care service for which the
3198 covered person received emergency services but has not been
3199 discharged from a facility, the covered person or the covered person's
3200 authorized representative may file a request for an expedited external
3201 review, or (II) a denial of coverage based on a determination that the
3202 recommended or requested health care service or treatment is
3203 experimental or investigational and the covered person's treating
3204 health care professional certifies in writing that such recommended or
3205 requested health care service or treatment would be significantly less
3206 effective if not promptly initiated, the covered person or the covered
3207 person's authorized representative may file a request for an expedited
3208 external review;

3209 (D) (i) A copy of the description of both the standard and expedited
3210 external review procedures the health carrier is required to provide,
3211 highlighting the provisions in the external review procedures that give
3212 the covered person or the covered person's authorized representative
3213 the opportunity to submit additional information and including any
3214 forms used to process an external review or an expedited external
3215 review;

3216 (ii) As part of any forms provided under subparagraph (D)(i) of this
3217 subdivision, an authorization form or other document approved by the
3218 commissioner that complies with the requirements of 45 CFR 164.508,
3219 as amended from time to time, by which the covered person shall

3220 authorize the health carrier and the covered person's treating health
3221 care professional to release, transfer or otherwise divulge, in
3222 accordance with sections 38a-975 to 38a-999a, inclusive, of the general
3223 statutes, the covered person's protected health information including
3224 medical records for purposes of conducting an external review or an
3225 expedited external review.

3226 (d) (1) A covered person or a covered person's authorized
3227 representative may file a request for an expedited external review of an
3228 adverse determination or a final adverse determination with the
3229 commissioner, except that an expedited external review shall not be
3230 provided for a retrospective review request of an adverse
3231 determination or a final adverse determination.

3232 (2) Such request may be filed at the time the covered person
3233 receives:

3234 (A) An adverse determination, if:

3235 (i) (I) The covered person has a medical condition for which the time
3236 period for completion of an expedited internal review of the adverse
3237 determination would seriously jeopardize the life or health of the
3238 covered person or would jeopardize the covered person's ability to
3239 regain maximum function; or

3240 (II) The denial of coverage is based on a determination that the
3241 recommended or requested health care service or treatment is
3242 experimental or investigational and the covered person's treating
3243 health care professional certifies in writing that such recommended or
3244 requested health care service or treatment would be significantly less
3245 effective if not promptly initiated; and

3246 (ii) The covered person or the covered person's authorized
3247 representative has filed a request for an expedited internal review of
3248 the adverse determination; or

3249 (B) A final adverse determination if:

3250 (i) The covered person has a medical condition where the time
3251 period for completion of a standard external review would seriously
3252 jeopardize the life or health of the covered person or would jeopardize
3253 the covered person's ability to regain maximum function;

3254 (ii) The final adverse determination concerns an admission,
3255 availability of care, continued stay or health care service for which the
3256 covered person received emergency services but has not been
3257 discharged from a facility; or

3258 (iii) The denial of coverage is based on a determination that the
3259 recommended or requested health care service or treatment is
3260 experimental or investigational and the covered person's treating
3261 health care professional certifies in writing that such recommended or
3262 requested health care service or treatment would be significantly less
3263 effective if not promptly initiated.

3264 (3) Such covered person or covered person's authorized
3265 representative shall not be required to file a request for an external
3266 review prior to, or at the same time as, the filing of a request for an
3267 expedited external review and shall not be precluded from filing a
3268 request for an external review, within the time periods set forth in
3269 subsection (e) of this section, if the request for an expedited external
3270 review is determined to be ineligible for such review.

3271 (e) (1) Not later than one hundred twenty calendar days after a
3272 covered person or a covered person's authorized representative
3273 receives a notice of an adverse determination or a final adverse
3274 determination, the covered person or the covered person's authorized
3275 representative may file a request for an external review or an
3276 expedited external review with the commissioner in accordance with
3277 this section.

3278 (2) Not later than one business day after the commissioner receives
3279 a request that is complete, the commissioner shall send a copy of such
3280 request to the health carrier that issued the adverse determination or
3281 the final adverse determination that is the subject of the request.

3282 (3) Not later than (A) five business days after the health carrier
3283 receives the copy of an external review request, or (B) one calendar day
3284 after the health carrier receives the copy of an expedited external
3285 review request, from the commissioner, the health carrier shall
3286 complete a preliminary review of the request to determine whether:

3287 (A) The individual is or was a covered person under the health
3288 benefit plan at the time the health care service was requested or, in the
3289 case of an external review of a retrospective review request, was a
3290 covered person in the health benefit plan at the time the health care
3291 service was provided;

3292 (B) The health care service that is the subject of the adverse
3293 determination or the final adverse determination is a covered service
3294 under the covered person's health benefit plan but for the health
3295 carrier's determination that the health care service is not covered
3296 because it does not meet the health carrier's requirements for medical
3297 necessity, appropriateness, health care setting, level of care or
3298 effectiveness;

3299 (C) If the health care service or treatment is experimental or
3300 investigational:

3301 (i) Is a covered benefit under the covered person's health benefit
3302 plan but for the health carrier's determination that the service or
3303 treatment is experimental or investigational for a particular medical
3304 condition;

3305 (ii) Is not explicitly listed as an excluded benefit under the covered
3306 person's health benefit plan;

3307 (iii) The covered person's treating health care professional has
3308 certified that one of the following situations is applicable:

3309 (I) Standard health care services or treatments have not been
3310 effective in improving the medical condition of the covered person;

3311 (II) Standard health care services or treatments are not medically

3312 appropriate for the covered person; or

3313 (III) There is no available standard health care service or treatment
3314 covered by the health carrier that is more beneficial than the
3315 recommended or requested health care service or treatment; and

3316 (iv) The covered person's treating health care professional:

3317 (I) Has recommended a health care service or treatment that the
3318 health care professional certifies, in writing, is likely to be more
3319 beneficial to the covered person, in the health care professional's
3320 opinion, than any available standard health care services or treatments;
3321 or

3322 (II) Is a licensed, board certified or board eligible health care
3323 professional qualified to practice in the area of medicine appropriate to
3324 treat the covered person's condition and has certified in writing that
3325 scientifically valid studies using accepted protocols demonstrate that
3326 the health care service or treatment requested by the covered person
3327 that is the subject of the adverse determination or the final adverse
3328 determination is likely to be more beneficial to the covered person than
3329 any available standard health care services or treatments;

3330 (D) The covered person has exhausted the health carrier's internal
3331 grievance process or the covered person or the covered person's
3332 authorized representative has filed a request for an expedited external
3333 review as provided under subsection (d) of this section; and

3334 (E) The covered person has provided all the information and forms
3335 required to process an external review or an expedited external review,
3336 including an authorization form as set forth in subparagraph (D)(ii) of
3337 subdivision (2) of subsection (c) of this section.

3338 (4) (A) Not later than (i) one business day after the preliminary
3339 review of an external review request, or (ii) the day the preliminary
3340 review of an expedited external review request is completed, the
3341 health carrier shall notify the commissioner, the covered person and, if

3342 applicable, the covered person's authorized representative in writing
3343 whether the request for an external review or an expedited external
3344 review is complete and eligible for such review. The commissioner
3345 may specify the form for the health carrier's notice of initial
3346 determination under this subdivision and any supporting information
3347 required to be included in the notice.

3348 (B) If the request:

3349 (i) Is not complete, the health carrier shall notify the commissioner
3350 and the covered person and, if applicable, the covered person's
3351 authorized representative in writing and include in the notice what
3352 information or materials are needed to perfect the request; or

3353 (ii) Is not eligible for external review or expedited external review,
3354 the health carrier shall notify the commissioner, the covered person
3355 and, if applicable, the covered person's authorized representative in
3356 writing and include in the notice the reasons for its ineligibility.

3357 (C) The notice of initial determination shall include a statement
3358 informing the covered person and, if applicable, the covered person's
3359 authorized representative that a health carrier's initial determination
3360 that the request for an external review or an expedited external review
3361 is ineligible for review may be appealed to the commissioner.

3362 (D) Notwithstanding a health carrier's initial determination that a
3363 request for an external review or an expedited external review is
3364 ineligible for review, the commissioner may determine, pursuant to
3365 the terms of the covered person's health benefit plan, that such request
3366 is eligible for such review and assign an independent review
3367 organization to conduct such review. Any such review shall be
3368 conducted in accordance with this section.

3369 (f) (1) Whenever the commissioner is notified pursuant to
3370 subparagraph (A) of subdivision (4) of subsection (e) of this section
3371 that a request is eligible for external review or expedited external
3372 review, the commissioner shall, not later than (A) one business day

3373 after receiving such notice for an external review, or (B) one calendar
3374 day after receiving such notice for an expedited external review:

3375 (i) Assign an independent review organization from the list of
3376 approved independent review organizations compiled and maintained
3377 by the commissioner pursuant to section 65 of this act to conduct the
3378 review and notify the health carrier of the name of the assigned
3379 independent review organization. Such assignment shall be done on a
3380 random basis among those approved independent review
3381 organizations qualified to conduct the particular review based on the
3382 nature of the health care service that is the subject of the adverse
3383 determination or the final adverse determination and other
3384 circumstances, including conflict of interest concerns as set forth in
3385 section 66 of this act; and

3386 (ii) Notify the covered person and, if applicable, the covered
3387 person's authorized representative in writing of the request's eligibility
3388 and acceptance for external review or expedited external review. For
3389 an external review, the commissioner shall include in such notice (I) a
3390 statement that the covered person or the covered person's authorized
3391 representative may submit, not later than five business days after the
3392 covered person or the covered person's authorized representative, as
3393 applicable, received such notice, additional information in writing to
3394 the assigned independent review organization that such organization
3395 shall consider when conducting the external review, and (II) where
3396 and how such additional information is to be submitted. If additional
3397 information is submitted later than five business days after the covered
3398 person or the covered person's authorized representative, as
3399 applicable, received such notice, the independent review organization
3400 may, but shall not be required to, accept and consider such additional
3401 information.

3402 (2) Not later than (A) five business days for an external review, or
3403 (B) one calendar day for an expedited external review, after the health
3404 carrier receives notice of the name of the assigned independent review
3405 organization from the commissioner, the health carrier or its designee

3406 utilization review company shall provide to the assigned independent
3407 review organization the documents and any information such health
3408 carrier or utilization review company considered in making the
3409 adverse determination or the final adverse determination.

3410 (3) The failure of the health carrier or its designee utilization review
3411 company to provide the documents and information within the time
3412 specified in subdivision (2) of this subsection shall not delay the
3413 conducting of the review.

3414 (4) (i) If the health carrier or its designee utilization review company
3415 fails to provide the documents and information within the time period
3416 specified in subdivision (2) of this subsection, the independent review
3417 organization may terminate the review and make a decision to reverse
3418 the adverse determination or the final adverse determination.

3419 (ii) Not later than one business day after terminating the review and
3420 making the decision to reverse the adverse determination or the final
3421 adverse determination, the independent review organization shall
3422 notify the commissioner, the health carrier, the covered person and, if
3423 applicable, the covered person's authorized representative in writing
3424 of such decision.

3425 (g) (1) The assigned independent review organization shall review
3426 all the information and documents received pursuant to subsection (f)
3427 of this section. In reaching a decision, the independent review
3428 organization shall not be bound by any decisions or conclusions
3429 reached during the health carrier's utilization review process.

3430 (2) Not later than one business day after receiving any information
3431 submitted by the covered person or the covered person's authorized
3432 representative pursuant to subparagraph (B) of subdivision (1) of
3433 subsection (f) of this section, the independent review organization
3434 shall forward such information to the health carrier.

3435 (3) (A) Upon the receipt of any information forwarded pursuant to
3436 subdivision (2) of this subsection, the health carrier may reconsider its

3437 adverse determination or the final adverse determination that is the
3438 subject of the review. Such reconsideration shall not delay or terminate
3439 the review.

3440 (B) The independent review organization shall terminate the review
3441 if the health carrier decides, upon completion of its reconsideration
3442 and notice to such organization as provided in subparagraph (C) of
3443 this subdivision, to reverse its adverse determination or its final
3444 adverse determination and provide coverage or payment for the health
3445 care service or treatment that is the subject of the adverse
3446 determination or the final adverse determination.

3447 (C) Not later than one business day after making the decision to
3448 reverse its adverse determination or its final adverse determination,
3449 the health carrier shall notify the commissioner, the assigned
3450 independent review organization, the covered person and, if
3451 applicable, the covered person's authorized representative in writing
3452 of such decision.

3453 (h) In addition to the documents and information received pursuant
3454 to subsection (f) of this section, the independent review organization
3455 shall consider, to the extent the documents or information are available
3456 and the independent review organization considers them appropriate,
3457 the following in reaching a decision:

3458 (1) The covered person's medical records;

3459 (2) The attending health care professional's recommendation;

3460 (3) Consulting reports from appropriate health care professionals
3461 and other documents submitted by the health carrier, the covered
3462 person, the covered person's authorized representative or the covered
3463 person's treating health care professional;

3464 (4) The terms of coverage under the covered person's health benefit
3465 plan to ensure that the independent review organization's decision is
3466 not contrary to the terms of coverage under such health benefit plan;

3467 (5) The most appropriate practice guidelines, which shall include
3468 applicable evidence-based standards and may include any other
3469 practice guidelines developed by the federal government, national or
3470 professional medical societies, medical boards or medical associations;

3471 (6) Any applicable clinical review criteria developed and used by
3472 the health carrier or its designee utilization review company; and

3473 (7) The opinion or opinions of the independent review
3474 organization's clinical peer or peers who conducted the review after
3475 considering subdivisions (1) to (6), inclusive, of this subsection.

3476 (i) (1) The independent review organization shall notify the
3477 commissioner, the health carrier, the covered person and, if applicable,
3478 the covered person's authorized representative in writing of its
3479 decision to uphold, reverse or revise the adverse determination or the
3480 final adverse determination, not later than:

3481 (A) For external reviews, forty-five calendar days after such
3482 organization receives the assignment from the commissioner to
3483 conduct such review;

3484 (B) For external reviews involving a determination that the
3485 recommended or requested health care service or treatment is
3486 experimental or investigational, twenty calendar days after such
3487 organization receives the assignment from the commissioner to
3488 conduct such review;

3489 (C) For expedited external reviews, as expeditiously as the covered
3490 person's medical condition requires, but not later than seventy-two
3491 hours after such organization receives the assignment from the
3492 commissioner to conduct such review; and

3493 (D) For expedited external reviews involving a determination that
3494 the recommended or requested health care service or treatment is
3495 experimental or investigational, as expeditiously as the covered
3496 person's medical condition requires, but not later than five calendar

3497 days after such organization receives the assignment from the
3498 commissioner to conduct such review.

3499 (2) Such notice shall include:

3500 (A) A general description of the reason for the request for the
3501 review;

3502 (B) The date the independent review organization received the
3503 assignment from the commissioner to conduct the review;

3504 (C) The date the review was conducted;

3505 (D) The date the organization made its decision;

3506 (E) The principal reason or reasons for its decision, including what
3507 applicable evidence-based standards, if any, were used as a basis for its
3508 decision;

3509 (F) The rationale for the organization's decision;

3510 (G) Reference to the evidence or documentation, including any
3511 evidence-based standards, considered by the organization in reaching
3512 its decision; and

3513 (H) For a review involving a determination that the recommended
3514 or requested health care service or treatment is experimental or
3515 investigational:

3516 (i) A description of the covered person's medical condition;

3517 (ii) A description of the indicators relevant to determining whether
3518 there is sufficient evidence to demonstrate that (I) the recommended or
3519 requested health care service or treatment is likely to be more
3520 beneficial to the covered person than any available standard health
3521 care services or treatments, and (II) the adverse risks of the
3522 recommended or requested health care service or treatment would not
3523 be substantially increased over those of available standard health care
3524 services or treatments;

3525 (iii) A description and analysis of any medical or scientific evidence
3526 considered in reaching the opinion;

3527 (iv) A description and analysis of any evidence-based standard; and

3528 (v) Information on whether the clinical peer's rationale for the
3529 opinion is based on the documents and information set forth in
3530 subsection (f) of this section.

3531 (3) Upon the receipt of a notice of the independent review
3532 organization's decision to reverse or revise an adverse determination
3533 or a final adverse determination, the health carrier shall immediately
3534 approve the coverage that was the subject of the adverse determination
3535 or the final adverse determination.

3536 Sec. 61. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
3537 maintain written records to document all grievances of adverse
3538 determinations it receives, including the notices and claims associated
3539 with such grievances, during a calendar year.

3540 (2) (A) Each health carrier shall maintain such records for not less
3541 than six years after the notice of an adverse determination that is the
3542 subject of a grievance was provided to a covered person or the covered
3543 person's authorized representative, as applicable, under section 57 of
3544 this act.

3545 (B) The health carrier shall make such records available for
3546 examination by covered persons, to the extent such records are
3547 permitted to be disclosed by law, the commissioner and appropriate
3548 federal oversight agencies upon request. Such records shall be
3549 maintained in a manner that is reasonably clear and accessible to the
3550 commissioner.

3551 (b) For each grievance the record shall contain, at a minimum, the
3552 following information: (1) A general description of the reason for the
3553 grievance; (2) the date the health carrier received the grievance; (3) the
3554 date of each review or, if applicable, review meeting of the grievance;

3555 (4) the resolution at each level of the grievance, if applicable; (5) the
3556 date of resolution at each such level, if applicable; and (6) the name of
3557 the covered person for whom the grievance was filed.

3558 (c) Each health carrier shall submit a report annually to the
3559 commissioner, in accordance with section 55 of this act, of the
3560 grievances it received.

3561 (d) (1) Each health carrier shall maintain written records of all
3562 requests for external reviews, whether such requests are for standard
3563 or expedited external reviews, that such health carrier receives notice
3564 of from the commissioner in a calendar year. The health carrier shall
3565 maintain such records in the aggregate by state where the covered
3566 person requesting such review resides and by each type of health
3567 benefit plan offered by the health carrier, and shall submit a report to
3568 the commissioner upon request, in a format prescribed by the
3569 commissioner.

3570 (2) Such report shall include, in the aggregate by state where the
3571 covered person requesting such review resides and by each type of
3572 health benefit plan:

3573 (A) The total number of requests for an external review, whether
3574 such requests were for a standard or expedited external review;

3575 (B) From the total number of such requests reported under
3576 subparagraph (A) of this subdivision, the number of requests
3577 determined eligible for a full external review, whether such requests
3578 were for a standard or expedited external review; and

3579 (C) Any other information the commissioner may request or
3580 require.

3581 (3) The health carrier shall retain the written records required
3582 pursuant to subdivision (1) of this subsection for not less than six years
3583 after the request for an external review or an expedited external review
3584 was received.

3585 Sec. 62. (NEW) (*Effective July 1, 2011*) The commissioner shall adopt
3586 regulations, in accordance with chapter 54 of the general statutes, to
3587 implement the provisions of sections 54 to 66, inclusive, of this act.

3588 Sec. 63. (NEW) (*Effective July 1, 2011*) (a) No utilization review
3589 company shall conduct utilization review in this state for a health
3590 benefit plan under the jurisdiction of the commissioner unless it is
3591 licensed by the commissioner. All licenses shall be renewed on an
3592 annual basis.

3593 (b) The annual license fee shall be three thousand dollars and shall
3594 be dedicated to the regulation of utilization review, except that the
3595 commissioner shall be authorized to use such funds as is necessary to
3596 (1) implement the provisions of sections 38a-91aa to 38a-91qq,
3597 inclusive, of the general statutes, and (2) contract with The University
3598 of Connecticut School of Medicine to provide any medical
3599 consultations necessary to carry out the commissioner's responsibilities
3600 under this title with respect to consumer and market conduct matters.

3601 (c) The request for licensure or renewal shall include the name,
3602 address, telephone number and normal business hours of the
3603 utilization review company, the name and telephone number of a
3604 person for the commissioner to contact. Any material changes in the
3605 information filed in accordance with this subsection shall be filed with
3606 the commissioner not later than thirty calendar days after the change.

3607 (d) The commissioner shall receive and investigate all grievances
3608 filed against utilization review companies by a covered person. The
3609 commissioner shall code, track and review all grievances. The
3610 commissioner may impose such penalties as authorized, in accordance
3611 with section 64 of this act.

3612 (e) In the absence of any contractual agreement to the contrary, the
3613 covered person or the covered person's authorized representative shall
3614 be responsible for requesting certification and for authorizing the
3615 covered person's treating health care professional to release, in a timely
3616 manner, all information necessary to conduct the review. A utilization

3617 review company shall permit the covered person, the covered person's
3618 authorized representative or the covered person's treating health care
3619 professional to assist in fulfilling that responsibility.

3620 Sec. 64. (NEW) (*Effective July 1, 2011*) (a) Whenever the
3621 commissioner has reason to believe that a utilization review company
3622 subject to sections 54 to 63, inclusive, of this act has been or is engaging
3623 in conduct in violation of said sections, and that a proceeding by the
3624 commissioner would be in the interest of the public, the commissioner
3625 shall issue and serve upon such company a statement of the charges in
3626 that respect and a notice of a hearing to be held at a time and place
3627 fixed in the notice, which shall not be less than thirty calendar days
3628 after the date of service. At the time and place fixed for such hearing,
3629 such company shall have an opportunity to be heard and to show
3630 cause why an order should not be made by the commissioner
3631 requiring such company to cease and desist from the alleged conduct
3632 complained of.

3633 (b) If, after such hearing, the commissioner determines that the
3634 utilization review company charged has engaged in a violation of
3635 section 57 of this act, the commissioner shall reduce the findings to
3636 writing and shall issue and cause to be served upon the utilization
3637 review company a copy of such findings and an order requiring such
3638 company to cease and desist from engaging in such violation. The
3639 commissioner may order any of the following:

3640 (1) Payment of a civil penalty of not more than one thousand five
3641 hundred dollars for each act or violation, provided such penalty shall
3642 not exceed an aggregate penalty of fifteen thousand dollars unless the
3643 company knew or reasonably should have known it was in violation of
3644 section 57 of this act, in which case the penalty shall be not more than
3645 seven thousand five hundred dollars for each act or violation, not to
3646 exceed an aggregate penalty of seventy-five thousand dollars in any
3647 six-month period;

3648 (2) Suspension or revocation of the utilization review company's

3649 license to do business in this state if it knew or reasonably should have
3650 known that it was in violation of section 57 of this act; or

3651 (3) Payment of such reasonable expenses as may be necessary to
3652 compensate the commissioner in connection with the proceedings
3653 under this subsection, which shall be dedicated exclusively to the
3654 regulation of utilization review.

3655 (c) Any company aggrieved by any such order of the commissioner
3656 may appeal therefrom in accordance with the provisions of section 4-
3657 183 of the general statutes, except venue for such appeal shall be in the
3658 judicial district of New Britain.

3659 (d) Any person who violates a cease and desist order of the
3660 commissioner made pursuant to this section and while such order is in
3661 effect shall, after notice and hearing and upon order of the
3662 commissioner, be subject to the following: (1) A civil penalty of not
3663 more than seventy-five thousand dollars; or (2) suspension or
3664 revocation of such person's license.

3665 Sec. 65. (NEW) (*Effective July 1, 2011*) (a) (1) The commissioner shall
3666 approve independent review organizations eligible to be assigned to
3667 conduct external reviews and expedited external reviews under section
3668 60 of this act.

3669 (2) The commissioner shall (A) develop an application form for the
3670 initial approval and for the reapproval of independent review
3671 organizations, and (B) maintain and periodically update a list of
3672 approved independent review organizations.

3673 (b) (1) Any independent review organization seeking to conduct
3674 external reviews and expedited external reviews under section 60 of
3675 this act shall submit the application form for approval or reapproval,
3676 as applicable, to the commissioner and shall include all documentation
3677 and information necessary for the commissioner to determine if the
3678 independent review organization satisfies the minimum qualifications
3679 established under this section.

3680 (2) An approval or reapproval shall be effective for two years,
3681 unless the commissioner determines before the expiration of such
3682 approval or reapproval that the independent review organization no
3683 longer satisfies the minimum qualifications established under this
3684 section.

3685 (3) Whenever the commissioner determines that an independent
3686 review organization has lost its accreditation or no longer satisfies the
3687 minimum requirements established under this section, the
3688 commissioner shall terminate the approval of the independent review
3689 organization and remove the independent review organization from
3690 the list of approved independent review organizations specified in
3691 subdivision (2) of subsection (a) of this section.

3692 (c) To be eligible for approval by the commissioner, an independent
3693 review organization shall:

3694 (1) Have and maintain written policies and procedures that govern
3695 all aspects of both the standard external review process and the
3696 expedited external review process set forth in section 60 of this act that
3697 include, at a minimum:

3698 (A) A quality assurance mechanism in place that ensures:

3699 (i) That external reviews and expedited external reviews are
3700 conducted within the specified time frames and required notices are
3701 provided in a timely manner;

3702 (ii) (I) The selection of qualified and impartial clinical peers to
3703 conduct such reviews on behalf of the independent review
3704 organization and the suitable matching of such peers to specific cases,
3705 and (II) employs or contracts with an adequate number of clinical
3706 peers to meet this objective;

3707 (iii) The confidentiality of medical and treatment records and
3708 clinical review criteria;

3709 (iv) That any person employed by or under contract with the

3710 independent review organization adheres to the requirements of
3711 section 60 of this act; and

3712 (B) A toll-free telephone number to receive information twenty-four
3713 hours a day, seven days a week, related to external reviews and
3714 expedited external reviews and that is capable of accepting, recording
3715 or providing appropriate instruction to incoming telephone callers
3716 during other than normal business hours;

3717 (2) Agree to maintain and provide to the commissioner the
3718 information set forth in section 66 of this act;

3719 (3) Not own or control, be a subsidiary of, be owned or controlled in
3720 any way by, or exercise control with a health benefit plan, a national,
3721 state or local trade association of health benefit plans, or a national,
3722 state or local trade association of health care professionals; and

3723 (4) Assign as a clinical peer a health care professional who meets the
3724 following minimum qualifications:

3725 (A) Is an expert in the treatment of the covered person's medical
3726 condition that is the subject of the review;

3727 (B) Is knowledgeable about the recommended health care service or
3728 treatment through recent or current actual clinical experience treating
3729 patients with the same or similar medical condition of the covered
3730 person;

3731 (C) Holds a nonrestricted license in a state of the United States and,
3732 for physicians, a current certification by a recognized American
3733 medical specialty board in the area or areas appropriate to the subject
3734 of the review; and

3735 (D) Has no history of disciplinary actions or sanctions, including
3736 loss of staff privileges or participation restrictions, that have been
3737 taken or are pending by any hospital, governmental agency or unit or
3738 regulatory body that raise a substantial question as to the clinical
3739 peer's physical, mental or professional competence or moral character.

3740 (d) (1) An independent review organization that is accredited by a
3741 nationally recognized private accrediting entity that has independent
3742 review accreditation standards that the commissioner has determined
3743 are equivalent to or exceed the minimum qualifications of this section
3744 shall be presumed to be in compliance with this section.

3745 (2) The commissioner shall initially review and periodically review
3746 the independent review organization accreditation standards of a
3747 nationally recognized private accrediting entity to determine whether
3748 such entity's standards are, and continue to be, equivalent to or exceed
3749 the minimum qualifications established under this section. The
3750 commissioner may accept a review conducted by the National
3751 Association of Insurance Commissioners for the purpose of the
3752 determination under this subdivision.

3753 (3) Upon request, a nationally recognized private accrediting entity
3754 shall make its current independent review organization accreditation
3755 standards available to the commissioner or the National Association of
3756 Insurance Commissioners in order for the commissioner to determine
3757 if such entity's standards are equivalent to or exceed the minimum
3758 qualifications established under this section. The commissioner may
3759 exclude any private accrediting entity that is not reviewed by the
3760 National Association of Insurance Commissioners.

3761 Sec. 66. (NEW) (*Effective July 1, 2011*) (a) The commissioner shall not
3762 assign an independent review organization, and no independent
3763 review organization shall assign a clinical peer, to conduct an external
3764 review or an expedited external review of a specified case if such
3765 organization or clinical peer has a material professional, familial or
3766 financial conflict of interest with any of the following:

3767 (1) The health carrier that is the subject of such review;

3768 (2) The covered person whose treatment is the subject of such
3769 review or the covered person's authorized representative;

3770 (3) Any officer, director or management employee of the health

3771 carrier that is the subject of such review;

3772 (4) The health care provider, the health care provider's medical
3773 group or independent practice association recommending the health
3774 care service or treatment that is the subject of such review;

3775 (5) The facility at which the recommended health care service or
3776 treatment would be provided; or

3777 (6) The developer or manufacturer of the principal drug, device,
3778 procedure or other therapy being recommended for the covered
3779 person whose treatment is the subject of such review.

3780 (b) To determine whether an independent review organization or a
3781 clinical peer of the independent review organization has a material
3782 professional, familial or financial conflict of interest for purposes of
3783 subsection (a) of this section, the commissioner shall consider
3784 situations in which the independent review organization to be
3785 assigned to conduct an external review or an expedited external
3786 review of a specified case or a clinical peer to be assigned by the
3787 independent review organization to conduct such review of a specified
3788 case may have an apparent professional, familial or financial
3789 relationship or connection with a person described in subsection (a) of
3790 this section, but the characteristics of such relationship or connection
3791 are such that they are not a material professional, familial or financial
3792 conflict of interest that results in the disapproval of the independent
3793 review organization or the clinical peer from conducting such review.

3794 (c) An independent review organization shall be unbiased. In
3795 addition to any other written procedures required under section 65 of
3796 this act, an independent review organization shall establish and
3797 maintain written procedures to ensure that it is unbiased.

3798 (d) No independent review organization or clinical peer working on
3799 behalf of an independent review organization or an employee, agent or
3800 contractor of an independent review organization shall be liable in
3801 damages to any person for any opinions rendered or acts or omissions

3802 performed within the scope of the organization's or person's duties
3803 during or upon completion of an external review or an expedited
3804 external review conducted pursuant to section 60 of this act, unless
3805 such opinion was rendered or act or omission performed in bad faith
3806 or involved gross negligence.

3807 (e) (1) Each independent review organization assigned by the
3808 commissioner to conduct a review pursuant to section 60 of this act
3809 shall maintain written records of all external reviews, whether
3810 standard or expedited external reviews, conducted by such
3811 organization in a calendar year. Such organization shall maintain such
3812 records in the aggregate by state where the covered person requesting
3813 such review resides and by health carrier, and shall submit a report to
3814 the commissioner upon request, in a format prescribed by the
3815 commissioner.

3816 (2) Such report shall include, in the aggregate by state where the
3817 covered person requesting such review resides and by health carrier:

3818 (A) The total number of requests for an external review, whether
3819 such requests were for a standard or an expedited external review;

3820 (B) The number of such requests resolved and, of those resolved, the
3821 number resolved upholding the adverse determination or final adverse
3822 determination and the number resolved reversing the adverse
3823 determination or final adverse determination;

3824 (C) The average length of time for resolution;

3825 (D) A summary of the types of coverages or cases for which a
3826 review was sought;

3827 (E) The number of such reviews that were terminated as a result of
3828 reconsideration by the health carrier of its adverse determination or
3829 final adverse determination after the receipt of additional information
3830 from the covered person or the covered person's authorized
3831 representative; and

3832 (F) Any other information the commissioner may request or require.

3833 (3) Each independent review organization shall retain the written
3834 records required pursuant to subdivision (1) of this subsection for not
3835 less than six years after the assignment of an external review or an
3836 expedited external review.

3837 (f) The commissioner shall adopt regulations, in accordance with
3838 chapter 54, to carry out the provisions of this section and sections 63 to
3839 65, inclusive, of this act.

3840 Sec. 67. Section 38a-478 of the general statutes is repealed and the
3841 following is substituted in lieu thereof (*Effective July 1, 2011*):

3842 As used in this section, sections [38a-478] 38a-478a to 38a-478o,
3843 inclusive, as amended by this act, and subsection (a) of section 38a-
3844 478s, as amended by this act:

3845 [(1) "Adverse determination" means a determination by a managed
3846 care organization, health insurer or utilization review company that an
3847 admission, service, procedure or extension of stay that is a covered
3848 benefit has been reviewed and, based upon the information provided,
3849 does not meet the managed care organization's, health insurer's or
3850 utilization review company's requirements for medical necessity,
3851 appropriateness, health care setting, level of care or effectiveness, and
3852 such requested admission, service, procedure or extension of stay, or
3853 payment for such admission, service, procedure or extension of stay
3854 has been denied, reduced or terminated.]

3855 [(2)] (1) "Commissioner" means the Insurance Commissioner.

3856 [(3)] (2) "Covered benefit" or "benefit" means a health care service to
3857 which an enrollee is entitled under the terms of a health benefit plan.

3858 [(4)] (3) [Except as provided in sections 38a-478m and 38a-478n,
3859 "enrollee"] "Enrollee" means a person who has contracted for or who
3860 participates in a managed care plan for such person or such person's
3861 eligible dependents.

3862 [(5)] (4) "Health care services" means services for the diagnosis,
3863 prevention, treatment, cure or relief of a health condition, illness,
3864 injury or disease.

3865 [(6)] (5) "Managed care organization" means an insurer, health care
3866 center, hospital or medical service corporation or other organization
3867 delivering, issuing for delivery, renewing, amending or continuing any
3868 individual or group health managed care plan in this state.

3869 [(7)] (6) "Managed care plan" means a product offered by a managed
3870 care organization that provides for the financing or delivery of health
3871 care services to persons enrolled in the plan through: (A)
3872 Arrangements with selected providers to furnish health care services;
3873 (B) explicit standards for the selection of participating providers; (C)
3874 financial incentives for enrollees to use the participating providers and
3875 procedures provided for by the plan; or (D) arrangements that share
3876 risks with providers, provided the organization offering a plan
3877 described under subparagraph (A), (B), (C) or (D) of this subdivision is
3878 licensed by the Insurance Department pursuant to chapter 698, 698a or
3879 700 and the plan includes utilization review, [pursuant to sections 38a-
3880 226 to 38a-226d, inclusive] as defined in section 54 of this act.

3881 [(8)] (7) "Preferred provider network" has the same meaning as
3882 provided in section 38a-479aa, as amended by this act.

3883 [(9)] (8) "Provider" or "health care provider" means a person licensed
3884 to provide health care services under chapters 370 to 373, inclusive, 375
3885 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

3886 [(10)] "Review entity" means an entity that conducts independent
3887 external reviews of adverse determinations. Such review entities
3888 include, but are not limited to, medical peer review organizations,
3889 independent utilization review companies, provided such
3890 organizations or companies are not related to or associated with any
3891 managed care organization or health insurer, and nationally
3892 recognized health experts or institutions approved by the Insurance
3893 Commissioner.]

3894 [(11)] (9) "Utilization review" has the same meaning as provided in
3895 section [38a-226] 54 of this act.

3896 [(12)] (10) "Utilization review company" has the same meaning as
3897 provided in section [38a-226] 54 of this act.

3898 Sec. 68. Subsection (c) of section 38a-19 of the general statutes is
3899 repealed and the following is substituted in lieu thereof (*Effective July*
3900 *1, 2011*):

3901 (c) The provisions of this section shall not apply to an order or
3902 decision of the commissioner made pursuant to section [38a-477b or
3903 38a-478n] 60 of this act.

3904 Sec. 69. Subsection (b) of section 38a-477b of the general statutes is
3905 repealed and the following is substituted in lieu thereof (*Effective July*
3906 *1, 2011*):

3907 (b) An insurer or health care center shall apply for approval of such
3908 rescission, cancellation or limitation by submitting such written
3909 information to the Insurance Commissioner on an application in such
3910 form as the commissioner prescribes. Such insurer or health care center
3911 shall provide a copy of the application for such approval to the insured
3912 or the insured's representative. Not later than seven business days
3913 after receipt of the application for such approval, the insured or the
3914 insured's representative shall have an opportunity to review such
3915 application and respond and submit relevant information to the
3916 commissioner with respect to such application. Not later than fifteen
3917 business days after the submission of information by the insured or the
3918 insured's representative, the commissioner shall issue a written
3919 decision on such application. The commissioner [may] shall only
3920 approve; [such rescission, cancellation]

3921 (1) Such rescission or limitation if the commissioner finds that [(1)]
3922 (A) the insured or such insured's representative submitted the written
3923 information [submitted] on or with the insurance application that was
3924 [false] fraudulent at the time such application was made, [and] (B) the

3925 insured or such insured's representative [knew or should have known
3926 of the falsity] intentionally misrepresented information therein [,] and
3927 such [submission] misrepresentation materially affects the risk or the
3928 hazard assumed by the insurer or health care center, or [(2)] (C) the
3929 information omitted from the insurance application was [knowingly]
3930 intentionally omitted by the insured or such insured's representative [,
3931 or the insured or such insured's representative should have known of
3932 such omission,] and such omission materially affects the risk or the
3933 hazard assumed by the insurer or health care center. Such decision
3934 shall be mailed to the insured, the insured's representative, if any, and
3935 the insurer or health care center; and

3936 (2) Such cancellation in accordance with the provisions set forth in
3937 the Public Health Service Act, 42 USC 300gg et seq., as amended from
3938 time to time.

3939 Sec. 70. Section 38a-478a of the general statutes is repealed and the
3940 following is substituted in lieu thereof (*Effective July 1, 2011*):

3941 On March [1, 1999, and] first annually, [thereafter,] the Insurance
3942 Commissioner shall submit a report [,] to the Governor and to the joint
3943 standing committees of the General Assembly having cognizance of
3944 matters relating to public health and [relating to] insurance,
3945 concerning the commissioner's responsibilities under the provisions of
3946 sections [38a-226 to 38a-226d, inclusive] 54 to 61, inclusive, of this act,
3947 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as
3948 amended by this act, and 38a-993. The report shall include: (1) A
3949 summary of the quality assurance plans submitted by managed care
3950 organizations pursuant to section 38a-478c along with suggested
3951 changes to improve such plans; (2) suggested modifications to the
3952 consumer report card developed under the provisions of section 38a-
3953 478l; (3) a summary of the commissioner's procedures and activities in
3954 conducting market conduct examinations of utilization review
3955 companies and preferred provider networks, including, but not limited
3956 to: (A) The number of desk and field audits completed during the
3957 previous calendar year; (B) a summary of findings of the desk and field

audits, including any recommendations made for improvements or modifications; (C) a description of complaints concerning managed care companies, and any preferred provider network that provides services to enrollees on behalf of the managed care organization, including a summary and analysis of any trends or similarities found in the managed care complaints filed by enrollees; (4) a summary of the complaints concerning managed care organizations received by the Insurance Department's Consumer Affairs Division and the commissioner under section [38a-478n] 60 of this act, including a summary and analysis of any trends or similarities found in the complaints received; (5) a summary of any violations the commissioner has found against any managed care organization or any preferred provider network that provides services to enrollees on behalf of the managed care organization; and (6) a summary of the issues discussed related to health care or managed care organizations at the Insurance Department's quarterly forums throughout the state.

Sec. 71. Section 38a-478b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Each managed care organization, as defined in section 38a-478, that fails to file the data, reports or information required by sections [38a-226 to 38a-226d] 54 to 61, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by this act, and 38a-993 shall pay a late fee of one hundred dollars per day for each day from the due date of such data, reports or information to the date of filing. Each managed care organization that files incomplete data, reports or information shall be so informed by the commissioner, shall be given a date by which to remedy such incomplete filing and shall pay said late fee commencing from the new due date.

(b) On June [1, 1998, and] first annually, [thereafter,] the commissioner shall submit [,] to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to public health and [matters relating to] insurance, a list of those managed care organizations that have failed to file any data,

3991 report or information required by sections [38a-226 to 38a-226d] 54 to
3992 61, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by
3993 this act, 38a-479aa, as amended by this act, and 38a-993.

3994 Sec. 72. Section 38a-478h of the general statutes is repealed and the
3995 following is substituted in lieu thereof (*Effective July 1, 2011*):

3996 (a) Each contract delivered, issued for delivery, renewed, amended
3997 or continued in this state [on and after October 1, 1997,] between a
3998 managed care organization and a participating provider shall require
3999 the provider to give at least sixty days' advance written notice to the
4000 managed care organization and shall require the managed care
4001 organization to give at least sixty days' advance written notice to the
4002 provider in order to withdraw from or terminate the agreement.

4003 (b) The provisions of this section shall not apply: (1) When lack of
4004 such notice is necessary for the health or safety of the enrollees; (2)
4005 when a provider has entered into a contract with a managed care
4006 organization that is found to be based on fraud or material
4007 misrepresentation; or (3) when a provider engages in any fraudulent
4008 activity related to the terms of his contract with the managed care
4009 organization.

4010 (c) No managed care organization shall take or threaten to take any
4011 action against any provider in retaliation for such provider's assistance
4012 to an enrollee under the provisions of [subsection (e) of section 38a-
4013 226c or section 38a-478n] section 60 of this act.

4014 Sec. 73. Subsection (d) of section 38a-478r of the general statutes is
4015 repealed and the following is substituted in lieu thereof (*Effective July*
4016 *1, 2011*):

4017 (d) The Insurance Commissioner [, after consultation with the
4018 working group convened pursuant to section 38a-478p,] may develop
4019 and disseminate to hospitals in this state a claims form system that will
4020 ensure that all hospitals consistently code for the presenting and
4021 diagnosis symptoms on all emergency claims.

4022 Sec. 74. Section 38a-478s of the general statutes is repealed and the
4023 following is substituted in lieu thereof (*Effective July 1, 2011*):

4024 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended
4025 by this act, or sections 54 to 61, inclusive, of this act shall be construed
4026 to apply to the arrangements of managed care organizations or health
4027 insurers offered to individuals covered under self-insured employee
4028 welfare benefit plans established pursuant to the federal Employee
4029 Retirement Income Security Act of 1974.

4030 (b) The provisions of sections 38a-478 to 38a-478o, inclusive, as
4031 amended by this act, and sections 54 to 61, inclusive, of this act shall
4032 not apply to any plan that provides for the financing or delivery of
4033 health care services solely for the purposes of workers' compensation
4034 benefits pursuant to chapter 568.

4035 Sec. 75. Section 38a-478t of the general statutes is repealed and the
4036 following is substituted in lieu thereof (*Effective July 1, 2011*):

4037 The Commissioner of Public Health may request and shall receive
4038 any data, report or information filed with the Insurance Commissioner
4039 pursuant to the provisions of sections [38a-226 to 38a-226d, inclusive]
4040 63 and 64 of this act, 38a-478 to 38a-478u, inclusive, as amended by this
4041 act, 38a-479aa, as amended by this act, and 38a-993.

4042 Sec. 76. Section 38a-478u of the general statutes is repealed and the
4043 following is substituted in lieu thereof (*Effective July 1, 2011*):

4044 The Insurance Commissioner may adopt regulations in accordance
4045 with the provisions of chapter 54 to implement the provisions of
4046 sections [38a-226 to 38a-226d, inclusive,] 38a-478 to 38a-478u, inclusive,
4047 as amended by this act, 38a-479aa, as amended by this act, and 38a-
4048 993.

4049 Sec. 77. Section 38a-479aa of the general statutes is repealed and the
4050 following is substituted in lieu thereof (*Effective July 1, 2011*):

4051 (a) As used in this part and subsection (b) of section 20-138b:

4052 (1) "Covered benefits" means health care services to which an
4053 enrollee is entitled under the terms of a managed care plan;

4054 (2) "Enrollee" means an individual who is eligible to receive health
4055 care services through a preferred provider network;

4056 (3) "Health care services" means health care related services or
4057 products rendered or sold by a provider within the scope of the
4058 provider's license or legal authorization, and includes hospital,
4059 medical, surgical, dental, vision and pharmaceutical services or
4060 products;

4061 (4) "Managed care organization" means (A) a managed care
4062 organization, as defined in section 38a-478, as amended by this act, (B)
4063 any other health insurer, or (C) a reinsurer with respect to health
4064 insurance;

4065 (5) "Managed care plan" means a managed care plan, as defined in
4066 section 38a-478, as amended by this act;

4067 (6) "Person" means an individual, agency, political subdivision,
4068 partnership, corporation, limited liability company, association or any
4069 other entity;

4070 (7) "Preferred provider network" means a person, which is not a
4071 managed care organization, but which pays claims for the delivery of
4072 health care services, accepts financial risk for the delivery of health
4073 care services and establishes, operates or maintains an arrangement or
4074 contract with providers relating to (A) the health care services
4075 rendered by the providers, and (B) the amounts to be paid to the
4076 providers for such services. "Preferred provider network" does not
4077 include (i) a workers' compensation preferred provider organization
4078 established pursuant to section 31-279-10 of the regulations of
4079 Connecticut state agencies, (ii) an independent practice association or
4080 physician hospital organization whose primary function is to contract
4081 with insurers and provide services to providers, (iii) a clinical
4082 laboratory, licensed pursuant to section 19a-30, whose primary

4083 payments for any contracted or referred services are made to other
4084 licensed clinical laboratories or for associated pathology services, or
4085 (iv) a pharmacy benefits manager responsible for administering
4086 pharmacy claims whose primary function is to administer the
4087 pharmacy benefit on behalf of a health benefit plan;

4088 (8) "Provider" means an individual or entity duly licensed or legally
4089 authorized to provide health care services; and

4090 (9) "Commissioner" means the Insurance Commissioner.

4091 (b) On and after May 1, 2004, no preferred provider network may
4092 enter into or renew a contractual relationship with a managed care
4093 organization unless the preferred provider network is licensed by the
4094 commissioner. On and after May 1, 2005, no preferred provider
4095 network may conduct business in this state unless it is licensed by the
4096 commissioner. Any person seeking to obtain or renew a license shall
4097 submit an application to the commissioner, on such form as the
4098 commissioner may prescribe, and shall include the filing described in
4099 this subsection, except that a person seeking to renew a license may
4100 submit only the information necessary to update its previous filing.
4101 Applications shall be submitted by March first of each year in order to
4102 qualify for the May first license issue or renewal date. The filing
4103 required from such preferred provider network shall include the
4104 following information: (1) The identity of the preferred provider
4105 network and any company or organization controlling the operation of
4106 the preferred provider network, including the name, business address,
4107 contact person, a description of the controlling company or
4108 organization and, where applicable, the following: (A) A certificate
4109 from the Secretary of the State regarding the preferred provider
4110 network's and the controlling company's or organization's good
4111 standing to do business in the state; (B) a copy of the preferred
4112 provider network's and the controlling company's or organization's
4113 financial statement completed in accordance with sections 38a-53 and
4114 38a-54, as applicable, for the end of its most recently concluded fiscal
4115 year, along with the name and address of any public accounting firm

4116 or internal accountant which prepared or assisted in the preparation of
4117 such financial statement; (C) a list of the names, official positions and
4118 occupations of members of the preferred provider network's and the
4119 controlling company's or organization's board of directors or other
4120 policy-making body and of those executive officers who are
4121 responsible for the preferred provider network's and controlling
4122 company's or organization's activities with respect to the health care
4123 services network; (D) a list of the preferred provider network's and the
4124 controlling company's or organization's principal owners; (E) in the
4125 case of an out-of-state preferred provider network, controlling
4126 company or organization, a certificate that such preferred provider
4127 network, company or organization is in good standing in its state of
4128 organization; (F) in the case of a Connecticut or out-of-state preferred
4129 provider network, controlling company or organization, a report of the
4130 details of any suspension, sanction or other disciplinary action relating
4131 to such preferred provider network, or controlling company or
4132 organization in this state or in any other state; and (G) the identity,
4133 address and current relationship of any related or predecessor
4134 controlling company or organization. For purposes of this
4135 subparagraph, "related" means that a substantial number of the board
4136 or policy-making body members, executive officers or principal
4137 owners of both companies are the same; (2) a general description of the
4138 preferred provider network and participation in the preferred provider
4139 network, including: (A) The geographical service area of and the
4140 names of the hospitals included in the preferred provider network; (B)
4141 the primary care physicians, the specialty physicians, any other
4142 contracting providers and the number and percentage of each group's
4143 capacity to accept new patients; (C) a list of all entities on whose behalf
4144 the preferred provider network has contracts or agreements to provide
4145 health care services; (D) a table listing all major categories of health
4146 care services provided by the preferred provider network; (E) an
4147 approximate number of total enrollees served in all of the preferred
4148 provider network's contracts or agreements; (F) a list of subcontractors
4149 of the preferred provider network, not including individual
4150 participating providers, that assume financial risk from the preferred

4151 provider network and to what extent each subcontractor assumes
4152 financial risk; (G) a contingency plan describing how contracted health
4153 care services will be provided in the event of insolvency; and (H) any
4154 other information requested by the commissioner; and (3) the name
4155 and address of the person to whom applications may be made for
4156 participation.

4157 (c) Any person developing a preferred provider network, or
4158 expanding a preferred provider network into a new county, pursuant
4159 to this section and subsection (b) of section 20-138b, shall publish a
4160 notice, in at least one newspaper having a substantial circulation in the
4161 service area in which the preferred provider network operates or will
4162 operate, indicating such planned development or expansion. Such
4163 notice shall include the medical specialties included in the preferred
4164 provider network, the name and address of the person to whom
4165 applications may be made for participation and a time frame for
4166 making application. The preferred provider network shall provide the
4167 applicant with written acknowledgment of receipt of the application.
4168 Each complete application shall be considered by the preferred
4169 provider network in a timely manner.

4170 (d) (1) Each preferred provider network shall file with the
4171 commissioner and make available upon request from a provider the
4172 general criteria for its selection or termination of providers. Disclosure
4173 shall not be required of criteria deemed by the preferred provider
4174 network to be of a proprietary or competitive nature that would hurt
4175 the preferred provider network's ability to compete or to manage
4176 health care services. For purposes of this section, criteria is of a
4177 proprietary or competitive nature if it has the tendency to cause
4178 providers to alter their practice pattern in a manner that would
4179 circumvent efforts to contain health care costs and criteria is of a
4180 proprietary nature if revealing the criteria would cause the preferred
4181 provider network's competitors to obtain valuable business
4182 information.

4183 (2) If a preferred provider network uses criteria that have not been

4184 filed pursuant to subdivision (1) of this subsection to judge the quality
4185 and cost-effectiveness of a provider's practice under any specific
4186 program within the preferred provider network, the preferred
4187 provider network may not reject or terminate the provider
4188 participating in that program based upon such criteria until the
4189 provider has been informed of the criteria that the provider's practice
4190 fails to meet.

4191 (e) Each preferred provider network shall permit the Insurance
4192 Commissioner to inspect its books and records.

4193 (f) Each preferred provider network shall permit the commissioner
4194 to examine, under oath, any officer or agent of the preferred provider
4195 network or controlling company or organization with respect to the
4196 use of the funds of the preferred provider network, company or
4197 organization, and compliance with (1) the provisions of this part, and
4198 (2) the terms and conditions of its contracts to provide health care
4199 services.

4200 (g) Each preferred provider network shall file with the
4201 commissioner a notice of any material modification of any matter or
4202 document furnished pursuant to this part, and shall include such
4203 supporting documents as are necessary to explain the modification.

4204 (h) Each preferred provider network shall maintain a minimum net
4205 worth of either (1) the greater of (A) two hundred fifty thousand
4206 dollars, or (B) an amount equal to eight per cent of its annual
4207 expenditures as reported on its most recent financial statement
4208 completed and filed with the commissioner in accordance with
4209 sections 38a-53 and 38a-54, as applicable, or (2) another amount
4210 determined by the commissioner.

4211 (i) Each preferred provider network shall maintain or arrange for a
4212 letter of credit, bond, surety, reinsurance, reserve or other financial
4213 security acceptable to the commissioner for the exclusive use of paying
4214 any outstanding amounts owed participating providers in the event of
4215 insolvency or nonpayment except that any remaining security may be

4216 used for the purpose of reimbursing managed care organizations in
4217 accordance with subsection (b) of section 38a-479bb. Such outstanding
4218 amount shall be at least an amount equal to the greater of (1) an
4219 amount sufficient to make payments to participating providers for two
4220 months determined on the basis of the two months within the past
4221 year with the greatest amounts owed by the preferred provider
4222 network to participating providers, (2) the actual outstanding amount
4223 owed by the preferred provider network to participating providers, or
4224 (3) another amount determined by the commissioner. Such amount
4225 may be credited against the preferred provider network's minimum
4226 net worth requirements set forth in subsection (h) of this section. The
4227 commissioner shall review such security amount and calculation on a
4228 quarterly basis.

4229 (j) Each preferred provider network shall pay the applicable license
4230 or renewal fee specified in section 38a-11. The commissioner shall use
4231 the amount of such fees solely for the purpose of regulating preferred
4232 provider networks.

4233 (k) In no event, including, but not limited to, nonpayment by the
4234 managed care organization, insolvency of the managed care
4235 organization, or breach of contract between the managed care
4236 organization and the preferred provider network, shall a preferred
4237 provider network bill, charge, collect a deposit from, seek
4238 compensation, remuneration or reimbursement from, or have any
4239 recourse against an enrollee or an enrollee's designee, other than the
4240 managed care organization, for covered benefits provided, except that
4241 the preferred provider network may collect any copayments,
4242 deductibles or other out-of-pocket expenses that the enrollee is
4243 required to pay pursuant to the managed care plan.

4244 (l) Each contract or agreement between a preferred provider
4245 network and a participating provider shall contain a provision that if
4246 the preferred provider network fails to pay for health care services as
4247 set forth in the contract, the enrollee shall not be liable to the
4248 participating provider for any sums owed by the preferred provider

4249 network or any sums owed by the managed care organization because
4250 of nonpayment by the managed care organization, insolvency of the
4251 managed care organization or breach of contract between the managed
4252 care organization and the preferred provider network.

4253 (m) Each utilization review determination made by or on behalf of a
4254 preferred provider network shall be made in accordance with [sections
4255 38a-226 to 38a-226d, inclusive, except that any initial appeal of a
4256 determination not to certify an admission, service, procedure or
4257 extension of stay shall be conducted in accordance with subdivision (7)
4258 of subsection (a) of section 38a-226c, and any subsequent appeal shall
4259 be referred to the managed care organization on whose behalf the
4260 preferred provider network provides services. The managed care
4261 organization shall conduct the subsequent appeal in accordance with
4262 said subdivision] section 57 of this act.

4263 (n) The requirements of subsections (h) and (i) of this section shall
4264 not apply to a consortium of federally qualified health centers funded
4265 by the state, providing services only to recipients of programs
4266 administered by the Department of Social Services. The Commissioner
4267 of Social Services shall adopt regulations, in accordance with chapter
4268 54, to establish criteria to certify any such federally qualified health
4269 center, including, but not limited to, minimum reserve fund
4270 requirements.

4271 Sec. 78. Subsection (d) of section 38a-479bb of the general statutes is
4272 repealed and the following is substituted in lieu thereof (*Effective July*
4273 *1, 2011*):

4274 (d) Each managed care organization shall ensure that any contract it
4275 has with a preferred provider network includes:

4276 (1) A provision that requires the preferred provider network to
4277 provide to the managed care organization at the time a contract is
4278 entered into, annually, and upon request of the managed care
4279 organization, (A) the financial statement completed in accordance with
4280 sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as

4281 amended by this act; (B) documentation that satisfies the managed care
4282 organization that the preferred provider network has sufficient ability
4283 to accept financial risk; (C) documentation that satisfies the managed
4284 care organization that the preferred provider network has appropriate
4285 management expertise and infrastructure; (D) documentation that
4286 satisfies the managed care organization that the preferred provider
4287 network has an adequate provider network taking into account the
4288 geographic distribution of enrollees and participating providers and
4289 whether participating providers are accepting new patients; (E) an
4290 accurate list of participating providers; and (F) documentation that
4291 satisfies the managed care organization that the preferred provider
4292 network has the ability to ensure the delivery of health care services as
4293 set forth in the contract;

4294 (2) A provision that requires the preferred provider network to
4295 provide to the managed care organization a quarterly status report that
4296 includes (A) information updating the financial statement completed
4297 in accordance with sections 38a-53 and 38a-54, as applicable, and
4298 section 38a-479aa, as amended by this act; (B) a report showing
4299 amounts paid to those providers who provide health care services on
4300 behalf of the managed care organization; (C) an estimate of payments
4301 due providers but not yet reported by providers; (D) amounts owed to
4302 providers for that quarter; and (E) the number of utilization review
4303 determinations not to certify an admission, service, procedure or
4304 extension of stay made by or on behalf of the preferred provider
4305 network and the outcome of such determination on appeal;

4306 (3) A provision that requires the preferred provider network to
4307 provide notice to the managed care organization not later than five
4308 business days after (A) any change involving the ownership structure
4309 of the preferred provider network; (B) financial or operational
4310 concerns arise regarding the financial viability of the preferred
4311 provider network; or (C) the preferred provider network's loss of a
4312 license in this or any other state;

4313 (4) A provision that if the managed care organization fails to pay for

4314 health care services as set forth in the contract, the enrollee will not be
4315 liable to the provider or preferred provider network for any sums
4316 owed by the managed care organization or preferred provider
4317 network;

4318 (5) A provision that the preferred provider network shall include in
4319 all contracts between the preferred provider network and participating
4320 providers a provision that if the preferred provider network fails to
4321 pay for health care services as set forth in the contract, for any reason,
4322 the enrollee shall not be liable to the participating provider or
4323 preferred provider network for any sums owed by the preferred
4324 provider network or any sums owed by the managed care
4325 organization because of nonpayment by the managed care
4326 organization, insolvency of the managed care organization or breach of
4327 contract between the managed care organization and the preferred
4328 provider network;

4329 (6) A provision requiring the preferred provider network to provide
4330 information to the managed care organization, satisfactory to the
4331 managed care organization, regarding the preferred provider
4332 network's reserves for financial risk;

4333 (7) A provision that (A) the preferred provider network or managed
4334 care organization shall post and maintain a letter of credit, bond,
4335 surety, reinsurance, reserve or other financial security acceptable to the
4336 commissioner, in order to satisfy the risk accepted by the preferred
4337 provider network pursuant to the contract, in an amount calculated in
4338 accordance with subsection (i) of section 38a-479aa, as amended by this
4339 act, (B) the managed care organization shall determine who posts and
4340 maintains the security required under subparagraph (A) of this
4341 subdivision, and (C) in the event of insolvency or nonpayment, such
4342 security shall be used by the preferred provider network, or other
4343 entity designated by the commissioner, solely for the purpose of
4344 paying any outstanding amounts owed participating providers, except
4345 that any remaining security may be used for the purpose of
4346 reimbursing the managed care organization for any payments made by

4347 the managed care organization to participating providers on behalf of
4348 the preferred provider network;

4349 (8) A provision under which the managed care organization is
4350 permitted, at the discretion of the managed care organization, to pay
4351 participating providers directly and in lieu of the preferred provider
4352 network in the event of insolvency or mismanagement by the
4353 preferred provider network and that payments made pursuant to this
4354 subdivision may be made or reimbursed from the security posted
4355 pursuant to subsection (b) of this section;

4356 (9) A provision transferring and assigning contracts between the
4357 preferred provider network and participating providers to the
4358 managed care organization for the provision of future services by
4359 participating providers to enrollees, at the discretion of the managed
4360 care organization, in the event the preferred provider network (A)
4361 becomes insolvent, (B) otherwise ceases to conduct business, as
4362 determined by the commissioner, or (C) demonstrates a pattern of
4363 nonpayment of authorized claims, as determined by the commissioner,
4364 for a period in excess of ninety days;

4365 (10) A provision that each contract or agreement between the
4366 preferred provider network and participating providers shall include a
4367 provision transferring and assigning contracts between the preferred
4368 provider network and participating providers to the managed care
4369 organization for the provision of future health care services by
4370 participating providers to enrollees, at the discretion of the managed
4371 care organization, in the event the preferred provider network (A)
4372 becomes insolvent, (B) otherwise ceases to conduct business, as
4373 determined by the commissioner, or (C) demonstrates a pattern of
4374 nonpayment of authorized claims, as determined by the commissioner,
4375 for a period in excess of ninety days;

4376 (11) A provision that the preferred provider network shall pay for
4377 the delivery of health care services and operate or maintain
4378 arrangements or contracts with providers in a manner consistent with

4379 the provisions of law that apply to the managed care organization's
4380 contracts with enrollees and providers; and

4381 (12) A provision that the preferred provider network shall ensure
4382 that utilization review determinations are made in accordance with
4383 [sections 38a-226 to 38a-226d, inclusive, except that any initial appeal
4384 of a determination not to certify an admission, service, procedure or
4385 extension of stay shall be made in accordance with subdivision (7) of
4386 subsection (a) of section 38a-226c. In cases where an appeal to reverse a
4387 determination not to certify is unsuccessful, the preferred provider
4388 network shall refer the case to the managed care organization which
4389 shall conduct the subsequent appeal, if any, in accordance with said
4390 subdivision] section 57 of this act.

4391 Sec. 79. Section 38a-479ee of the general statutes is repealed and the
4392 following is substituted in lieu thereof (*Effective July 1, 2011*):

4393 (a) If the Insurance Commissioner determines that a preferred
4394 provider network or managed care organization, or both, has not
4395 complied with any applicable provision of this part [, sections 38a-226
4396 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
4397 amended by this act, the commissioner may (1) order the preferred
4398 provider network or managed care organization, or both if both have
4399 not complied, to cease and desist all operations in violation of this part
4400 or said sections; (2) terminate or suspend the preferred provider
4401 network's license; (3) institute a corrective action against the preferred
4402 provider network or managed care organization, or both if both have
4403 not complied; (4) order the payment of a civil penalty by the preferred
4404 provider network or managed care organization, or both if both have
4405 not complied, of not more than one thousand dollars for each and
4406 every act or violation; (5) order the payment of such reasonable
4407 expenses as may be necessary to compensate the commissioner in
4408 conjunction with any proceedings held to investigate or enforce
4409 violations of this part [, sections 38a-226 to 38a-226d, inclusive,] or
4410 sections 38a-815 to 38a-819, inclusive, as amended by this act; and (6)
4411 use any of the commissioner's other enforcement powers to obtain

4412 compliance with this part [, sections 38a-226 to 38a-226d, inclusive,] or
4413 sections 38a-815 to 38a-819, inclusive, as amended by this act. The
4414 commissioner may hold a hearing concerning any matter governed by
4415 this part [, sections 38a-226 to 38a-226d, inclusive,] or sections 38a-815
4416 to 38a-819, inclusive, as amended by this act, in accordance with
4417 section 38a-16. Subject to the same confidentiality and liability
4418 protections set forth in subsections (c) and (k) of section 38a-14, the
4419 commissioner may engage the services of attorneys, appraisers,
4420 independent actuaries, independent certified public accountants or
4421 other professionals and specialists to assist the commissioner in
4422 conducting an investigation under this section, the cost of which shall
4423 be borne by the managed care organization or preferred provider
4424 network, or both, that is the subject of the investigation.

4425 (b) If a preferred provider network fails to comply with any
4426 applicable provision of this part [, sections 38a-226 to 38a-226d,
4427 inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended by this
4428 act, the commissioner may assign or require the preferred provider
4429 network to assign its rights and obligations under any contract with
4430 participating providers in order to ensure that covered benefits are
4431 provided.

4432 (c) The commissioner shall receive and investigate (1) any grievance
4433 filed against a preferred provider network or managed care
4434 organization, or both, by an enrollee or an enrollee's designee
4435 concerning matters governed by this part [, sections 38a-226 to 38a-
4436 226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended
4437 by this act, or (2) any referral from the Office of the Healthcare
4438 Advocate pursuant to section 38a-1041, as amended by this act. The
4439 commissioner shall code, track and review such grievances and
4440 referrals. The preferred provider network or managed care
4441 organization, or both, shall provide the commissioner with all
4442 information necessary for the commissioner to investigate such
4443 grievances and referrals. The information collected by the
4444 commissioner pursuant to this section shall be maintained as
4445 confidential and shall not be disclosed to any person except (A) to the

4446 extent necessary to carry out the purposes of this part [, sections 38a-
4447 226 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
4448 amended by this act, (B) as allowed under this title, (C) to the
4449 Healthcare Advocate, and (D) information concerning the nature of
4450 any grievance or referral and the commissioner's final determination
4451 shall be a public record, as defined in section 1-200, provided no
4452 personal information, as defined in section 38a-975, shall be disclosed.
4453 The commissioner shall report to the Healthcare Advocate on the
4454 resolution of any matter referred to the commissioner by the
4455 Healthcare Advocate.

4456 Sec. 80. Section 38a-479ff of the general statutes is repealed and the
4457 following is substituted in lieu thereof (*Effective July 1, 2011*):

4458 No health insurer, health care center, utilization review company, as
4459 defined in section [38a-226] 54 of this act, or preferred provider
4460 network, as defined in section 38a-479aa, as amended by this act, shall
4461 take or threaten to take any adverse personnel or coverage-related
4462 action against any enrollee, provider or employee in retaliation for
4463 such enrollee, provider or employee (1) filing a complaint with the
4464 Insurance Commissioner or the Office of the Healthcare Advocate, or
4465 (2) disclosing information to the Insurance Commissioner concerning
4466 any violation of this part [, sections 38a-226 to 38a-226d, inclusive,] or
4467 sections 38a-815 to 38a-819, inclusive, as amended by this act, unless
4468 such disclosure violates the provisions of chapter 705 or the privacy
4469 provisions of the federal Health Insurance Portability and
4470 Accountability Act of 1996, [(P.L. 104-191) (HIPAA)] P.L. 104-191, as
4471 amended from time to time, or regulations adopted thereunder. Any
4472 enrollee, provider or employee who is aggrieved by a violation of this
4473 section may bring a civil action in the Superior Court to recover
4474 damages and attorneys' fees and costs.

4475 Sec. 81. Section 38a-483c of the general statutes is repealed and the
4476 following is substituted in lieu thereof (*Effective July 1, 2011*):

4477 (a) Each individual health insurance policy delivered, issued for

4478 delivery, renewed, amended or continued in this state on or after
4479 January 1, 2000, shall define the extent to which it provides coverage
4480 for experimental treatments.

4481 (b) No such health insurance policy may deny a procedure,
4482 treatment or the use of any drug as experimental if such procedure,
4483 treatment or drug, for the illness or condition being treated, or for the
4484 diagnosis for which it is being prescribed, has successfully completed a
4485 phase III clinical trial of the federal Food and Drug Administration.

4486 (c) Any person who has been diagnosed with a condition that
4487 creates a life expectancy in that person of less than two years and who
4488 has been denied an otherwise covered procedure, treatment or drug on
4489 the grounds that it is experimental may request an expedited appeal as
4490 provided in section [38a-226c] 58 of this act and may appeal a denial
4491 thereof to the Insurance Commissioner in accordance with the
4492 procedures established in section [38a-478n] 60 of this act.

4493 [(d) For the purposes of conducting an appeal pursuant to section
4494 38a-478n on the grounds that an otherwise covered procedure,
4495 treatment or drug is experimental, the basis of such an appeal shall be
4496 the medical efficacy of such procedure, treatment or drug. The entity
4497 conducting the review may consider whether the procedure, treatment
4498 or drug (1) has been approved by the National Institute of Health or
4499 the American Medical Association, (2) is listed in the United States
4500 Pharmacopoeia Drug Information Guide for Health Care Professionals
4501 (USP-DI), the American Medical Association Drug Evaluations (AMA-
4502 DE), or the American Society of Hospital Pharmacists' American
4503 Hospital Formulary Service Drug Information (AHFS-DI), or (3) is
4504 currently in a phase III clinical trial of the federal Food and Drug
4505 Administration.]

4506 Sec. 82. Section 38a-513b of the general statutes is repealed and the
4507 following is substituted in lieu thereof (*Effective July 1, 2011*):

4508 (a) Each group health insurance policy delivered, issued for
4509 delivery, renewed, amended or continued in this state on or after

4510 January 1, 2000, shall define the extent to which it provides coverage
4511 for experimental treatments.

4512 (b) No such health insurance policy may deny a procedure,
4513 treatment or the use of any drug as experimental if such procedure,
4514 treatment or drug, for the illness or condition being treated, or for the
4515 diagnosis for which it is being prescribed, has successfully completed a
4516 phase III clinical trial of the federal Food and Drug Administration.

4517 (c) Any person who has been diagnosed with a condition that
4518 creates a life expectancy in that person of less than two years and who
4519 has been denied an otherwise covered procedure, treatment or drug on
4520 the grounds that it is experimental may request an expedited appeal as
4521 provided in section [38a-226c] 58 of this act and may appeal a denial
4522 thereof to the Insurance Commissioner in accordance with the
4523 procedures established in section [38a-478n] 60 of this act.

4524 [(d) For the purposes of conducting an appeal pursuant to section
4525 38a-478n on the grounds that an otherwise covered procedure,
4526 treatment or drug is experimental, the basis of such an appeal shall be
4527 the medical efficacy of such procedure, treatment or drug. The entity
4528 conducting the review may consider whether the procedure, treatment
4529 or drug (1) has been approved by the National Institute of Health or
4530 the American Medical Association, (2) is listed in the United States
4531 Pharmacopoeia Drug Information Guide for Health Care Professionals
4532 (USP-DI), the American Medical Association Drug Evaluations (AMA-
4533 DE), or the American Society of Hospital Pharmacists' American
4534 Hospital Formulary Service Drug Information (AHFS-DI), or (3) is
4535 currently in a phase III clinical trial of the federal Food and Drug
4536 Administration.]

4537 Sec. 83. Subsection (c) of section 38a-504f of the general statutes is
4538 repealed and the following is substituted in lieu thereof (*Effective July*
4539 *1, 2011*):

4540 (c) The insured, or the provider with the insured's written consent,
4541 may appeal any denial of coverage for medical necessity to an external,

4542 independent review pursuant to section [38a-478n] 60 of this act. Such
4543 external review shall be conducted by a properly qualified review
4544 agent whom the department has determined does not have a conflict
4545 of interest regarding the cancer clinical trial.

4546 Sec. 84. Subsection (c) of section 38a-542f of the general statutes is
4547 repealed and the following is substituted in lieu thereof (*Effective July*
4548 *1, 2011*):

4549 (c) The insured, or the provider with the insured's written consent,
4550 may appeal any denial of coverage for medical necessity to an external,
4551 independent review pursuant to section [38a-478n] 60 of this act. Such
4552 external review shall be conducted by a properly qualified review
4553 agent whom the department has determined does not have a conflict
4554 of interest regarding the cancer clinical trial.

4555 Sec. 85. Subdivision (22) of section 38a-816 of the general statutes is
4556 repealed and the following is substituted in lieu thereof (*Effective July*
4557 *1, 2011*):

4558 (22) Any violation of [section 38a-478m] sections 57 to 59, inclusive,
4559 of this act.

4560 Sec. 86. Subdivision (3) of section 38a-1040 of the general statutes is
4561 repealed and the following is substituted in lieu thereof (*Effective July*
4562 *1, 2011*):

4563 (3) "Managed care plan" means a product offered by a managed care
4564 organization that provides for the financing or delivery of health care
4565 services to persons enrolled in the plan through: (A) Arrangements
4566 with selected providers to furnish health care services; (B) explicit
4567 standards for the selection of participating providers; (C) financial
4568 incentives for enrollees to use the participating providers and
4569 procedures provided for by the plan; or (D) arrangements that share
4570 risks with providers, provided the organization offering a plan
4571 described under subparagraph (A), (B), (C) or (D) of this subdivision is
4572 licensed by the Insurance Department pursuant to chapter 698, 698a or

4573 700 and that the plan includes utilization review, [pursuant to sections
4574 38a-226 to 38a-226d, inclusive] as defined in section 54 of this act.

4575 Sec. 87. Subsections (b) and (c) of section 38a-1041 of the general
4576 statutes are repealed and the following is substituted in lieu thereof
4577 (*Effective July 1, 2011*):

4578 (b) The Office of the Healthcare Advocate may:

4579 (1) Assist health insurance consumers with managed care plan
4580 selection by providing information, referral and assistance to
4581 individuals about means of obtaining health insurance coverage and
4582 services;

4583 (2) Assist health insurance consumers to understand their rights and
4584 responsibilities under managed care plans;

4585 (3) Provide information to the public, agencies, legislators and
4586 others regarding problems and concerns of health insurance
4587 consumers and make recommendations for resolving those problems
4588 and concerns;

4589 (4) Assist consumers with the filing of complaints and appeals,
4590 including filing appeals with a managed care organization's internal
4591 appeal or grievance process and the external appeal process
4592 established under [section 38a-478n] sections 57 to 60, inclusive, of this
4593 act;

4594 (5) Analyze and monitor the development and implementation of
4595 federal, state and local laws, regulations and policies relating to health
4596 insurance consumers and recommend changes it deems necessary;

4597 (6) Facilitate public comment on laws, regulations and policies,
4598 including policies and actions of health insurers;

4599 (7) Ensure that health insurance consumers have timely access to the
4600 services provided by the office;

4601 (8) Review the health insurance records of a consumer who has
4602 provided written consent for such review;

4603 (9) Create and make available to employers a notice, suitable for
4604 posting in the workplace, concerning the services that the Healthcare
4605 Advocate provides;

4606 (10) Establish a toll-free number, or any other free calling option, to
4607 allow customer access to the services provided by the Healthcare
4608 Advocate;

4609 (11) Pursue administrative remedies on behalf of and with the
4610 consent of any health insurance consumers;

4611 (12) Adopt regulations, pursuant to chapter 54, to carry out the
4612 provisions of sections 38a-1040 to 38a-1050, inclusive, as amended by
4613 this act; and

4614 (13) Take any other actions necessary to fulfill the purposes of
4615 sections 38a-1040 to 38a-1050, inclusive, as amended by this act.

4616 (c) The Office of the Healthcare Advocate shall make a referral to
4617 the Insurance Commissioner if the Healthcare Advocate finds that a
4618 preferred provider network may have engaged in a pattern or practice
4619 that may be in violation of sections [38a-226 to 38a-226d, inclusive,]
4620 38a-479aa to 38a-479gg, inclusive, as amended by this act, or 38a-815 to
4621 38a-819, inclusive, as amended by this act.

4622 Sec. 88. (*Effective July 1, 2011*) Notwithstanding the provisions of
4623 sections 38a-183, 38a-481 and 38a-513 of the general statutes, a health
4624 carrier, as defined in section 1 of this act, shall certify to the Insurance
4625 Commissioner, in a form and manner prescribed by said
4626 commissioner, that any forms or endorsements relating to utilization
4627 review, the health carrier's internal grievance process, external review
4628 or expedited external review that are filed by such health carrier
4629 pursuant to section 38a-183, 38a-481 or 38a-513 of the general statutes
4630 for use on or after July 1, 2011, are in compliance with sections 54 to 66,

4631 inclusive, of this act and the Patient Protection and Affordable Care
 4632 Act, P.L. 111-148, as amended from time to time, and any regulations
 4633 adopted thereunder. Upon receipt by said commissioner of such filing
 4634 and certification, the health carrier may use such forms or
 4635 endorsements until such time as said commissioner, after notice and
 4636 hearing, disapproves their use. A health carrier may use the
 4637 certification procedure as set forth in this section until June 30, 2012.

4638 Sec. 89. Sections 38a-226 to 38a-226d, inclusive, 38a-478m, 38a-478n
 4639 and 38a-478p of the general statutes are repealed. (*Effective July 1, 2011*)

4640 Sec. 90. Sections 19a-710 to 19a-723, inclusive, of the general statutes
 4641 are repealed. (*Effective September 1, 2011*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2011</i>	New section
Sec. 2	<i>July 1, 2011</i>	New section
Sec. 3	<i>July 1, 2011</i>	New section
Sec. 4	<i>July 1, 2011</i>	New section
Sec. 5	<i>July 1, 2011</i>	New section
Sec. 6	<i>July 1, 2011</i>	New section
Sec. 7	<i>July 1, 2011</i>	New section
Sec. 8	<i>from passage</i>	New section
Sec. 9	<i>July 1, 2011</i>	New section
Sec. 10	<i>July 1, 2011</i>	38a-513f
Sec. 11	<i>from passage</i>	New section
Sec. 12	<i>July 1, 2011</i>	19a-654
Sec. 13	<i>from passage</i>	New section
Sec. 14	<i>from passage</i>	New section
Sec. 15	<i>January 1, 2012</i>	38a-816(15)(B)
Sec. 16	<i>January 1, 2012</i>	38a-479b
Sec. 17	<i>January 1, 2012</i>	New section
Sec. 18	<i>January 1, 2012</i>	New section
Sec. 19	<i>January 1, 2012</i>	New section
Sec. 20	<i>October 1, 2011</i>	New section
Sec. 21	<i>October 1, 2011</i>	New section
Sec. 22	<i>October 1, 2011</i>	New section

Sec. 23	October 1, 2011	New section
Sec. 24	October 1, 2011	New section
Sec. 25	October 1, 2011	New section
Sec. 26	October 1, 2011	New section
Sec. 27	October 1, 2011	New section
Sec. 28	October 1, 2011	New section
Sec. 29	October 1, 2011	New section
Sec. 30	October 1, 2011	New section
Sec. 31	October 1, 2011	New section
Sec. 32	October 1, 2011	New section
Sec. 33	October 1, 2011	New section
Sec. 34	October 1, 2011	New section
Sec. 35	October 1, 2011	38a-15(a)
Sec. 36	October 1, 2011	38a-11(a)
Sec. 37	from passage	38a-497
Sec. 38	from passage	New section
Sec. 39	from passage	5-259(a)
Sec. 40	from passage	5-259(f)
Sec. 41	from passage	38a-476(b)
Sec. 42	from passage	New section
Sec. 43	from passage	New section
Sec. 44	from passage	New section
Sec. 45	from passage	38a-546
Sec. 46	from passage	38a-564(17)
Sec. 47	from passage	38a-477b(b)
Sec. 48	from passage	38a-567(1)(D)
Sec. 49	January 1, 2012	38a-478l(b)
Sec. 50	January 1, 2012	38a-477c
Sec. 51	January 1, 2012	38a-478c
Sec. 52	January 1, 2012	38a-478g(b)
Sec. 53	from passage	New section
Sec. 54	July 1, 2011	New section
Sec. 55	July 1, 2011	New section
Sec. 56	July 1, 2011	New section
Sec. 57	July 1, 2011	New section
Sec. 58	July 1, 2011	New section
Sec. 59	July 1, 2011	New section
Sec. 60	July 1, 2011	New section
Sec. 61	July 1, 2011	New section
Sec. 62	July 1, 2011	New section

Sec. 63	<i>July 1, 2011</i>	New section
Sec. 64	<i>July 1, 2011</i>	New section
Sec. 65	<i>July 1, 2011</i>	New section
Sec. 66	<i>July 1, 2011</i>	New section
Sec. 67	<i>July 1, 2011</i>	38a-478
Sec. 68	<i>July 1, 2011</i>	38a-19(c)
Sec. 69	<i>July 1, 2011</i>	38a-477b(b)
Sec. 70	<i>July 1, 2011</i>	38a-478a
Sec. 71	<i>July 1, 2011</i>	38a-478b
Sec. 72	<i>July 1, 2011</i>	38a-478h
Sec. 73	<i>July 1, 2011</i>	38a-478r(d)
Sec. 74	<i>July 1, 2011</i>	38a-478s
Sec. 75	<i>July 1, 2011</i>	38a-478t
Sec. 76	<i>July 1, 2011</i>	38a-478u
Sec. 77	<i>July 1, 2011</i>	38a-479aa
Sec. 78	<i>July 1, 2011</i>	38a-479bb(d)
Sec. 79	<i>July 1, 2011</i>	38a-479ee
Sec. 80	<i>July 1, 2011</i>	38a-479ff
Sec. 81	<i>July 1, 2011</i>	38a-483c
Sec. 82	<i>July 1, 2011</i>	38a-513b
Sec. 83	<i>July 1, 2011</i>	38a-504f(c)
Sec. 84	<i>July 1, 2011</i>	38a-542f(c)
Sec. 85	<i>July 1, 2011</i>	38a-816(22)
Sec. 86	<i>July 1, 2011</i>	38a-1040(3)
Sec. 87	<i>July 1, 2011</i>	38a-1041(b) and (c)
Sec. 88	<i>July 1, 2011</i>	New section
Sec. 89	<i>July 1, 2011</i>	Repealer section
Sec. 90	<i>September 1, 2011</i>	Repealer section